Massachusetts

UNIFORM APPLICATION
FY 2009 - STATE PLAN

COMMUNITY MENTAL HEALTH SERVICES
BLOCK GRANT

OMB - Approved 08/06/2008 - Expires 08/31/2011

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Center for Mental Health Services
Division of State and Community Systems Development

Introduction:

The CMHS Block Grant application format provides the means for States to comply with the reporting provisions of the Public Health Service Act (42 USC 300x-21-64), as implemented by the Interim Final Rule and the Tobacco Regulation for the SAPT Block Grant (45 CFR Part 96, parts XI and IV, respectively).

Public reporting burden for this collection of information is estimated to average 563 hours per response for sections I-III, 50 hours per response for Section IV-A and 42 hours per response for Section IV-B, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to SAMHSA Reports Clearance Officer; Paperwork Reduction Project (0930-0080); Room 16-105, Parklawn Building; 5600 Fishers Lane, Rockville, MD 20857.

An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number. The OMB control number for this project is 0930-0168.

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FACE SHEET

FISCAL YEAR/S COVERED BY THE PLAN

__FY2009 __FY 2009-2010 _X_FY 2009-2011

STATE NAME: Massachusetts

DUNS #: 112070516

I. AGENCY TO RECEIVE GRANT

AGENCY: Executive Office of Health & Human Services

ORGANIZATIONAL UNIT: Department of Mental Health

STREET ADDRESS: 25 Staniford Street

CITY: Boston STATE: MA ZIP: 02114-2503

TELEPHONE: 617-626-8084 FAX: 617-626-8225

II. OFFICIAL IDENTIFIED BY GOVERNOR AS RESPONSIBLE FOR ADMINISTRATION OF THE GRANT

NAME: JudyAnn Bigby, MD TITLE: Secretary

AGENCY: Executive Office of Health & Human Services

ORGANIZATIONAL UNIT: Department of Mental Health

STREET ADDRESS: 25 Staniford Street

CITY: Boston STATE: MA ZIP CODE: 02114-2503

TELEPHONE: (617) 626-8084 FAX: (617) 626-8225

III. STATE FISCAL YEAR

FROM: 07/01/2008 TO: 06/30/2009

IV. PERSON TO CONTACT WITH QUESTIONS REGARDING THE APPLICATION

NAME: Beth Lucas TITLE: Director of Quality Improvement

AGENCY: Department of Mental Health

ORGANIZATIONAL UNIT: Clinical & Professional Services

STREET ADDRESS: 25 Staniford Street

CITY: Boston STATE: MA ZIP: 02114-2503

TELEPHONE: 617-626-8084 FAX: 617-626-8225 EMAIL: Beth.Lucas@.state.ma.us

Massachusetts

Executive Summary

Please respond by writing an Executive Summary of your current year's application.

Executive Summary

In September 2007, Barbara A. Leadholm, M.S., M.B.A., was named the commissioner of the Massachusetts Department of Mental Health (DMH). She articulated her vision for DMH in the overarching message of *Recovery and Resiliency Through Partnership*. This vision is grounded in DMH's commitment to provide consumers with improved access to services and is built upon the priorities of increasing awareness of respect for consumers and families, transforming case management services, and creating an infrastructure for continuous quality improvement.

In 2008, as part of the Commissioner's vision of increased consumer voice and participation in the activities and operations of DMH, the consumer affairs office was consolidated with the agency's communications office to create the Office of Communications and Consumer Affairs. This office is headed by a professional director who also is a family member and who oversees all internal and external communications for the Department. Staff includes the Director of Consumer Affairs, the Consumer Affairs Information and Referral Specialist, and the Communications Coordinator. To date, this office has initiated a DMH consumer newsletter, "Perspectives," the first issue of which was distributed statewide in June and will be published every two months.

The consumer vision for a transformed mental health system also includes the development of Recovery Learning Communities (RLCs) funded by DMH in each of the six DMH Areas. The first three were established in May 2007 and the next three began in Spring 2008. The RLCs are run by and for consumers. They are networks of peer support, education, and advocacy. Although RLCs operate out of an office hub, they exist as a resource to support a wide array of activities that take place in a variety of community settings and programs. The RLCs also provide support and training to certified peer specialists and peer workers, a growing workforce of individuals with lived experience within Massachusetts.

In order to ensure that quality management and improvement inform the operations of DMH, Commissioner Leadholm established a Quality Council in November 2007. The Quality Council consists of Senior Staff, Area Directors and the DMH Consumer Affairs staff. The functions of the Quality Council, as defined in its charter document are to: bridge local operations and planning with the strategic goals of DMH, stakeholders and the administration; promote data transparency; involve people with lived experience and their families; address health disparities and service gaps; and engage leadership and staff in a culture of quality improvement.

After creating a charter document, the Quality Council shifted its focus to the development of a Quality Framework. This Framework represents a new paradigm of how DMH will forward its mission of Recovery and Resiliency through renewed focus on priority areas of community integration, recovery, health and wellness, and access to services and supports. While grounded in the vision and values of DMH, the Framework is also in careful alignment with activities and trends occurring throughout federal and state government. At the federal level, the Framework incorporates concepts, goals and

measures put forward in the President's New Freedom Commission report, SAMHSA's National Outcome Measures, the Mental Health Statistics Improvement Program's proposed measures from its Quality Report, and the Centers for Medicare and Medicaid Services' Quality Framework.

At the state level the Quality Council and senior leadership are involved in significant activity occurring in the areas of quality and outcome measurement. During FY 2008, Governor Patrick announced the priorities of his administration. The Executive Office of Health and Human Services (EOHHS), under the leadership of Secretary Bigby, developed a subset of priority areas in alignment with those of the Governor. These priorities or goal areas are: Economic Growth and Development; Operational Priorities; Safe Communities; Wellness and Quality of Health Care; and World Class Education. The intent of this project, known as EHS Results, is to promote a performance management culture that identifies cross-agency goals, fosters collaborations, celebrates successes, shares outcomes and identifies policy opportunities. DMH and its Quality Council are actively working with EOHHS to identify sub-goals and outcome measures and to identify areas for improvement and collaboration. It is important to note that the priorities identified through these efforts are consistent with those identified at the federal level, including quality health care, housing and education.

Another priority within DMH is the construction of a new state-of-the-art psychiatric hospital. Massachusetts has been a leader in caring for people with mental illness since it built the first public asylum in America. In recent decades, as advances in care and treatment for individuals with mental illness, together with recognition of the need to partner with consumers to sustain their recovery in less restrictive environments, have shifted the focus to the community, DMH has steadily closed inpatient facilities and reinvested the savings into community programs. However, there remains a need for inpatient care, and the challenge is how to provide that care in facilities that offer state-of-the-art treatment in environments that promote recovery and encourage individuals to return to their communities.

As a result of a legislative mandate to study DMH's inpatient capacity and need, DMH determined that it could further reduce inpatient bed capacity, that the needed capacity in the central part of the state could be consolidated into one facility and that the two current facilities in this part of the state have outlasted their expected lifespan. The solution, endorsed by a bi-partisan, cross-constituency Commission created by the legislature, was to close both state hospitals, and to build a new state-of-the-art facility to serve the central part of Massachusetts. After a painstaking review of site plans, conceptual models and alternative land use scenarios, the Commission overwhelmingly chose to recommend the site of the original Worcester State Hospital for the new building. The new facility is designed for 260 adult beds, 30 adolescent inpatient beds, and 30 Intensive Residential Treatment Program (IRTP) beds

Bond funding was approved during FY 2008, and construction is slated to be completed in late 2011 or early 2012.

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To further its mission to provide services that are flexible and person-centered, DMH is currently redesigning its community-based service system and intends to re-procure its adult community mental health service system in stages over the next three years. DMH is committed to developing a service system that truly embraces the values of *Recovery and Resiliency Through Partnership* with clients and family members, emphasizing rehabilitation, person-centered and client-driven care. The system will be flexible and responsive to changing client needs. It must foster recovery and wellness, individual choice and rehabilitation. An evaluation of the strengths and weaknesses of how DMH currently contracts for services is part of the redesign work. DMH is determining how it can manage the provision and purchase of services that support fiscal innovation, flexibility and accountability. A Request for Information (RFI) was recently issued by DMH to seek public recommendations as to how best to redesign its services.

The most comprehensive interagency work related to youth from birth to 21 is planning for the implementation of the Children's Behavioral Health Initiative, of which the remedy for the Rosie D EPSDT lawsuit is the first phase. The remedy will significantly increase access to intensive community-based services for children with serious emotional disturbance who are enrolled in MassHealth, as the Medicaid program in Massachusetts is known. In the lawsuit, Plaintiffs argued successfully that Massachusetts was failing to provide adequate coverage for "intensive home-based services" for children with severe emotional disturbance and that if more intensive home-based services are available, the need for psychiatric hospitalizations and out-of-home placements would be reduced. The final court judgment addresses education, outreach and screening; assessment and diagnosis; intensive care coordination and treatment planning; and the following services: crisis management; home and community based services in home behavioral and in-home therapy services, and mentor services for the child and for the parent. Mental health screening by primary care clinicians began December 31, 2007, use of the Massachusetts CANS (Child and Adolescent Needs and Strengths), a standardized assessment tool, will begin November 30, 2008, and all services are required to be in place by June 30, 2009. This fall, DMH will begin using the Massachusetts version of the CANS for eligibility determination and for periodic reviews of clients receiving case management services. It will mark the first time that the Department of Children and Families (the former Department of Social Services renamed by the Legislature as of July 1, 2008), DMH and Medicaid providers will be using the same assessment instrument. Two-thirds of the children currently case managed by DMH have MassHealth coverage and are expected to be eligible for these EPSDT services as well as many children served by the Department of Children and Families and some served by the Department of Public Health and the Department of Youth Services. Given that new Medicaid reimbursable services, will be available for children currently served with state agency dollars, DMH and its sister agencies are working together to review their current service array and service delivery systems in order to create a more seamless and more cost efficient system of high quality behavioral health care. The DMH commissioner chairs the CBHI Executive Team that includes the commissioners of the Departments of Public Health, Children and Families, Youth Services, Medicaid, their senior staff, and leadership from the Secretariat.

Attachment A

COMMUNITY MENTAL HEALTH SERVICES BLOCK GRANT FUNDING AGREEMENTS

FISCAL YEAR 2009

I hereby certify that Massachusetts agrees to comply with the following sections of Title V of the Public Health Service Act [42 U.S.C. 300x-1 et seq.]

Section 1911:

Subject to Section 1916, the State[1] will expend the grant only for the purpose of:

i. Carrying out the plan under Section 1912(a) [State Plan for Comprehensive Community Mental Health Services] by the State for the fiscal year involved:

ii. Evaluating programs and services carried out under the plan; and

iii. Planning, administration, and educational activities related to providing services under the plan.

Section 1912

(c)(1)& (2) [As a funding agreement for a grant under Section 1911 of this title] The Secretary establishes and disseminates definitions for the terms adults with a serious mental illness and children with a severe emotional disturbance and the States will utilize such methods [standardized methods, established by the Secretary] in making estimates [of the incidence and prevalence in the State of serious mental illness among adults and serious emotional disturbance among children].

Section 1913:

(a)(1)(C) In the case for a grant for fiscal year 2008, the State will expend for such system [of integrated services described in section 1912(b)(3)] not less than an amount equal to the amount expended by the State for the fiscal year 1994.

[A system of integrated social services, educational services, juvenile services and substance abuse services that, together with health and mental health services, will be provided in order for such children to receive care appropriate for their multiple needs (which includes services provided under the Individuals with Disabilities Education Act)].

(b)(1) The State will provide services under the plan only through appropriate, qualified community programs (which may include community mental health centers, child mental-health programs, psychosocial rehabilitation programs, mental health peer-support programs, and mental-health primary consumer-directed programs).

(b)(2) The State agrees that services under the plan will be provided through community mental health centers only if the centers meet the criteria specified in subsection (c).

21. The term State shall hereafter be understood to include Territories.

(C)(1) With respect to mental health services, the centers provide services as follows:

(A) Services principally to individuals residing in a defined geographic area (referred to as a service area)
(B) Outpatient services, including specialized outpatient services for children, the elderly, individuals with a serious mental illness, and residents of the service areas of the centers who have been discharged from inpatient treatment at a mental health facility.
(C) 24-hour-a-day emergency care services.
(D) Day treatment or other partial hospitalization services, or psychosocial rehabilitation services.
(E) Screening for patients being considered for admissions to State mental health facilities to determine the appropriateness of such admission.

(2) The mental health services of the centers are provided, within the limits of the capacities of the centers, to any individual residing or employed in the service area of the center regardless of ability to pay for such services.

(3) The mental health services of the centers are available and accessible promptly, as appropriate and in a manner which preserves human dignity and assures continuity and high quality care.

Section 1914:

The State will establish and maintain a State mental health planning council in accordance with the conditions described in this section.
(b) The duties of the Council are:
(1) to review plans provided to the Council pursuant to section 1915(a) by the State involved and to submit to the State any recommendations of the Council for modifications to the plans;
(2) to serve as an advocate for adults with a serious mental illness, children with a severe emotional disturbance, and other individuals with mental illness or emotional problems; and
(3) to monitor, review, and evaluate, not less than once each year, the allocation and adequacy of mental health services within the State.

(c)(1) A condition under subsection (a) for a Council is that the Council is to be composed of residents of the State, including representatives of:

(A) the principle State agencies with respect to:
(i) mental health, education, vocational rehabilitation, criminal justice, housing, and social services; and
(ii) the development of the plan submitted pursuant to Title XIX of the Social Security Act;
(B) public and private entities concerned with the need, planning, operation, funding, and use of mental health services and related support services;
(C) adults with serious mental illnesses who are receiving (or have received) mental health services; and
(D) the families of such adults or families of children with emotional disturbance.

(2) A condition under subsection (a) for a Council is that:

(A) with respect to the membership of the Council, the ratio of parents of children with a serious emotional disturbance to other members of the Council is sufficient to provide adequate representation of such children in the deliberations of the Council; and

(B) not less than 50 percent of the members of the Council are individuals who are not State employees or providers of mental health services.

Section 1915:

(a)(1) State will make available to the State mental health planning council for its review under section 1914 the State plan submitted under section 1912(a) with respect to the grant and the report of the State under section 1942(a) concerning the preceding fiscal year.

(2) The State will submit to the Secretary any recommendations received by the State from the Council for modifications to the State plan submitted under section 1912(a) (without regard to whether the State has made the recommended modifications) and comments on the State plan implementation report on the preceding fiscal year under section 1942(a).

(b)(1) The State will maintain State expenditures for community mental health services at a level that is not less than the average level of such expenditures maintained by the State for the 2-year period preceding the fiscal year for which the State is applying for the grant.

Section 1916:

(a) The State agrees that it will not expend the grant:

(1) to provide inpatient services;

(2) to make cash payments to intended recipients of health services;

(3) to purchase or improve land, purchase, construct, or permanently improve (other than minor remodeling) any building or other facility, or purchase major medical equipment;

(4) to satisfy any requirement for the expenditure of non-Federal funds as a condition of the receipt of Federal funds; or

(5) to provide financial assistance to any entity other than a public or nonprofit entity.

(b) The State agrees to expend not more than 5 percent of the grant for administrative expenses with respect to the grant.

Section 1941:

The State will make the plan required in section 1912 as well as the State plan implementation report for the preceding fiscal year required under Section 1942(a) public within the State in such manner as to facilitate comment from any person (including any Federal or other public agency) during the development of the plan (including any revisions) and after the submission of the plan to the Secretary.

Section 1942:

(a) The State agrees that it will submit to the Secretary a report in such form and containing such information as the Secretary determines (after consultation with the States) to be necessary for securing a record and description of:

(1) the purposes for which the grant received by the State for the preceding fiscal year under the program involved were expended and a description of the activities of the State under the program; and
(2) the recipients of amounts provided in the grant.

(b) The State will, with respect to the grant, comply with Chapter 75 of Title 31, United Stated Code. [Audit Provision]

(c) The State will:
(1) make copies of the reports and audits described in this section available for public inspection within the State; and
(2) provide copies of the report under subsection (a), upon request, to any interested person (including any public agency).

Section 1943:

(a) The State will:
(1)(A) for the fiscal year for which the grant involved is provided, provide for independent peer review to assess the quality, appropriateness, and efficacy of treatment services provided in the State to individuals under the program involved; and
(B) ensure that, in the conduct of such peer review, not fewer than 5 percent of the entities providing services in the State under such program are reviewed (which 5 percent is representative of the total population of such entities);
(2) permit and cooperate with Federal investigations undertaken in accordance with section 1945 [Failure to Comply with Agreements]; and
(3) provide to the Secretary any data required by the Secretary pursuant to section 505 and will cooperate with the Secretary in the development of uniform criteria for the collection of data pursuant to such section

(b) The State has in effect a system to protect from inappropriate disclosure patient records maintained by the State in connection with an activity funded under the program involved or by any entity, which is receiving amounts from the grant.

_____ _____

Governor Date
JudyAnn Bigby, MD, Secretary

OMB Approval No. 0920-0428

CERTIFICATIONS

1. CERTIFICATION REGARDING DEBARMENT AND SUSPENSION

The undersigned (authorized official signing for the applicant organization) certifies to the best of his or her knowledge and belief, that the applicant, defined as the primary participant in accordance with 45 CFR Part 76, and its principals:

(a) are not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from covered transactions by any Federal Department or agency;

(b) have not within a 3-year period preceding this proposal been convicted of or had a civil judgment rendered against them for commission of fraud or a criminal offense in connection with obtaining, attempting to obtain, or performing a public (Federal, State, or local) transaction or contract under a public transaction; violation of Federal or State antitrust statutes or commission of embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements, or receiving stolen property;

(c) are not presently indicted or otherwise criminally or civilly charged by a governmental entity (Federal, State, or local) with commission of any of the offenses enumerated in paragraph (b) of this certification; and

(d) have not within a 3-year period preceding this application/proposal had one or more public transactions (Federal, State, or local) terminated for cause or default.

Should the applicant not be able to provide this certification, an explanation as to why should be placed after the assurances page in the application package.

The applicant agrees by submitting this proposal that it will include, without modification, the clause titled "Certification Regarding Debarment, Suspension, In eligibility, and Voluntary Exclusion--Lower Tier Covered Transactions" in all lower tier covered transactions (i.e., transactions with sub- grantees and/or contractors) and in all solicitations for lower tier covered transactions in accordance with 45 CFR Part 76.

2. CERTIFICATION REGARDING DRUG-FREE WORKPLACE REQUIREMENTS

The undersigned (authorized official signing for the applicant organization) certifies that the applicant will, or will continue to, provide a drug-free workplace in accordance with 45 CFR Part 76 by:

(a) Publishing a statement notifying employees that the unlawful manufacture, distribution, dispensing, possession or use of a controlled substance is prohibited in the grantee's workplace and specifying the actions that will be taken against employees for violation of such prohibition;

(b) Establishing an ongoing drug-free awareness program to inform employees about--
  (1) The dangers of drug abuse in the workplace;
  (2) The grantee's policy of maintaining a drug-free workplace;
  (3) Any available drug counseling, rehabilitation, and employee assistance programs; and
  (4) The penalties that may be imposed upon employees for drug abuse violations occurring in the workplace;

(c) Making it a requirement that each employee to be engaged in the performance of the grant be given a copy of the statement required by paragraph (a) above;

(d) Notifying the employee in the statement required by paragraph (a), above, that, as a condition of employment under the grant, the employee will--
  (1) Abide by the terms of the statement; and
  (2) Notify the employer in writing of his or her conviction for a violation of a criminal drug statute occurring in the workplace no later than five calendar days after such conviction;

(e) Notifying the agency in writing within ten calendar days after receiving notice under paragraph (d)(2) from an employee or otherwise receiving actual notice of such conviction. Employers of convicted employees must provide notice, including position title, to every grant officer or other designee on whose grant activity the convicted employee was working, unless the Federal agency has designated a central

point for the receipt of such notices. Notice shall include the identification number(s) of each affected grant;

(f) Taking one of the following actions, within 30 calendar days of receiving notice under paragraph (d) (2), with respect to any employee who is so convicted--
  (1) Taking appropriate personnel action against such an employee, up to and including termination, consistent with the requirements of the Rehabilitation Act of 1973, as amended; or
  (2) Requiring such employee to participate satisfactorily in a drug abuse assistance or rehabilitation program approved for such purposes by a Federal, State, or local health, law enforcement, or other appropriate agency;

(g) Making a good faith effort to continue to maintain a drug-free workplace through implementation of paragraphs (a), (b), (c), (d), (e), and (f).

For purposes of paragraph (e) regarding agency notification of criminal drug convictions, the DHHS has designated the following central point for receipt of such notices:

Office of Grants and Acquisition Management
Office of Grants Management
Office of the Assistant Secretary for Management and Budget
Department of Health and Human Services
200 Independence Avenue, S.W., Room 517-D
Washington, D.C. 20201

3. CERTIFICATION REGARDING LOBBYING

Title 31, United States Code, Section 1352, entitled "Limitation on use of appropriated funds to influence certain Federal contracting and financial transactions," generally prohibits recipients of Federal grants and cooperative agreements from using Federal (appropriated) funds for lobbying the Executive or Legislative Branches of the Federal Government in connection with a SPECIFIC grant or cooperative agreement. Section 1352 also requires that each person who requests or receives a Federal grant or cooperative agreement must disclose lobbying undertaken with non-Federal (non-appropriated) funds. These requirements apply to grants and cooperative agreements EXCEEDING $100,000 in total costs (45 CFR Part 93).

The undersigned (authorized official signing for the applicant organization) certifies, to the best of his or her knowledge and belief, that:

(1) No Federal appropriated funds have been paid or will be paid, by or on behalf of the undersigned, to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any Federal contract, the making of any Federal grant, the making of any Federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement.

(2) If any funds other than Federally appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, loan, or cooperative agreement, the undersigned shall complete and submit Standard Form-LLL, "Disclosure of Lobbying Activities," in accordance with its instructions. (If needed, Standard Form-LLL, "Disclosure of Lobbying Activities," its instructions, and continuation sheet are included at the end of this application form.)

(3) The undersigned shall require that the language of this certification be included in the award documents for all subawards at all tiers (including subcontracts, subgrants, and contracts under grants, loans and cooperative agreements) and that all subrecipients shall certify and disclose accordingly.

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by Section 1352, U.S. Code. Any person who fails to file the required certification shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.

4. CERTIFICATION REGARDING PROGRAM FRAUD CIVIL REMEDIES ACT (PFCRA)

The undersigned (authorized official signing for the applicant organization) certifies that the statements herein are true, complete, and accurate to the best of his or her knowledge, and that he or she is aware that any false, fictitious, or fraudulent statements or claims may subject him or her to criminal, civil, or administrative penalties. The undersigned agrees that the applicant organization will comply with the Public Health Service terms and conditions of award if a grant is awarded as a result of this application.

5. CERTIFICATION REGARDING ENVIRONMENTAL TOBACCO SMOKE

Public Law 103-227, also known as the Pro-Children Act of 1994 (Act), requires that smoking not be permitted in any portion of any indoor facility owned or leased or contracted for by an entity and used routinely or regularly for the provision of health, day care, early childhood development services, education or library services to children under the age of 18, if the services are funded by Federal programs either directly or through State or local governments, by Federal grant, contract, loan, or loan guarantee. The law also applies to children's services that are provided in indoor facilities that are constructed, operated, or maintained with such Federal funds. The law does not apply to children's services provided in private residence, portions of facilities used for inpatient drug or alcohol treatment, service providers whose sole source of applicable Federal funds is Medicare or Medicaid, or facilities where WIC coupons are redeemed.

Failure to comply with the provisions of the law may result in the imposition of a civil monetary penalty of up to $1,000 for each violation and/or the imposition of an administrative compliance order on the responsible entity.

By signing the certification, the undersigned certifies that the applicant organization will comply with the requirements of the Act and will not allow smoking within any portion of any indoor facility used for the provision of services for children as defined by the Act.

The applicant organization agrees that it will require that the language of this certification be included in any subawards which contain provisions for children's services and that all subrecipients shall certify accordingly.

The Public Health Services strongly encourages all grant recipients to provide a smoke-free workplace and promote the non-use of tobacco products. This is consistent with the PHS mission to protect and advance the physical an mental health of the American people.

SIGNATURE OF AUTHORIZED CERTIFYING OFFICIAL	TITLE Secretary
APPLICANT ORGANIZATION Executive Office of Health & Human Services	DATE SUBMITTED

DISCLOSURE OF LOBBYING ACTIVITIES

Approved by OMB
0348-0046

Complete this form to disclose lobbying activities pursuant to 31 U.S.C. 1352
(See reverse for public burden disclosure.)

1. **Type of Federal Action:**	2. **Status of Federal Action**	3. **Report Type:**
☐ a. contract b. grant c. cooperative agreement d. loan e. loan guarantee f. loan insurance	☐ a. bid/offer/application b. initial award c. post-award	☐ a. initial filing b. material change **For Material Change Only:** Year _____ Quarter _____ date of last report _____

4. **Name and Address of Reporting Entity:**	5. **If Reporting Entity in No. 4 is Subawardee, Enter Name and Address of Prime:**
Prime Subawardee Tier _____ , *if known:* **Congressional District**, *if known:*	**Congressional District,** *if known:*
6. Federal Department/Agency:	7. **Federal Program Name/Description:** **CFDA Number**, *if applicable:* _____
8. **Federal Action Number,** *if known:*	9. **Award Amount,** *if known:* **$**
10. a. Name and Address of Lobbying Entity *(if individual, last name, first name, MI):*	**b. Individuals Performing Services** *(including address if different from No. 10a.)* *(last name, first name, MI):*
11. **Information requested through this form is authorized by title 31 U.S.C. section 1352. This disclosure of lobbying activities is a material representation of fact upon which reliance was placed by the tier above when this transaction was made or entered into. This disclosure is required pursuant to 31 U.S.C. 1352. This information will be reported to the Congress semi-annually and will be available for public inspection. Any person who fails to file the required disclosure shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.**	**Signature:** _____ **Print Name:** _____ **Title:** _____ **Telephone No.:** _____ **Date:** _____
Federal Use Only:	Authorized for Local Reproduction Standard Form - LLL (Rev. 7-97)

INSTRUCTIONS FOR COMPLETION OF SF-LLL, DISCLOSURE OF LOBBYING ACTIVITIES

This disclosure form shall be completed by the reporting entity, whether subawardee or prime Federal recipient, at the initiation or receipt of a covered Federal action, or a material change to a previous filing, pursuant to title 31 U.S.C. Section 1352. The filing of a form is required for each payment or agreement to make payment to any lobbying entity for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with a covered Federal action. Use the SF-LLL-A Continuation Sheet for additional information if the space on the form is inadequate. Complete all items that apply for both the initial filing and material change report. Refer to the implementing guidance published by the Office of Management and Budget for additional information.

1. Identify the type of covered Federal action for which lobbying activity is and/or has been secured to influence the outcome of a covered Federal action.

2. Identify the status of the covered Federal action.

3. Identify the appropriate classification of this report. If this is a follow-up report caused by a material change to the information previously reported, enter the year and quarter in which the change occurred. Enter the date of the last previously submitted report by this reporting entity for this covered Federal action.

4. Enter the full name, address, city, state and zip code of the reporting entity. Include Congressional District, if known. Check the appropriate classification of the reporting entity that designates if it is, or expects to be, a prime or subaward recipient. Identify the tier of the subawardee, e.g., the first subawardee of the prime is the 1st tier. Subawards include but are not limited to subcontracts, subgrants and contract awards under grants.

5. If the organization filing the report in item 4 checks "subawardee", then enter the full name, address, city, state and zip code of the prime Federal recipient. Include Congressional District, if known.

6. Enter the name of the Federal agency making the award or loan commitment. Include at least one organizational level below agency name, if known. For example, Department of Transportation, United States Coast Guard.

7. Enter the Federal program name or description for the covered Federal action (item 1). If known, enter the full Catalog of Federal Domestic Assistance (CFDA) number for grants, cooperative agreements, loans, and loan commitments.

8. Enter the most appropriate Federal identifying number available for the Federal action identified in item 1 [e.g., Request for Proposal (RFP) number; Invitation for Bid (IFB) number; grant announcement number; the contract, grant, or loan award number; the application/proposal control number assigned by the Federal agency]. Include prefixes, e.g., ‘‘RFP-DE-90-001.’’

9. For a covered Federal action where there has been an award or loan commitment by the Federal agency, enter the Federal amount of the award/loan commitment for the prime entity identified in item 4 or 5.

10. (a) Enter the full name, address, city, state and zip code of the lobbying entity engaged by the reporting entity identified in item 4 to influence the covered Federal action.

    (b) Enter the full names of the individual(s) performing services, and include full address if different from 10(a). Enter Last Name, First Name, and Middle Initial (MI).

11. Enter the amount of compensation paid or reasonably expected to be paid by the reporting entity (item 4) to the lobbying entity (item 10). Indicate whether the payment has been made (actual) or will be made (planned). Check all boxes that apply. If this is a material change report, enter the cumulative amount of payment made or planned to be made.

ASSURANCES - NON-CONSTRUCTION PROGRAMS

Note: Certain of these assurances may not be applicable to your project or program. If you have questions, please contact the awarding agency. Further, certain Federal awarding agencies may require applicants to certify to additional assurances. If such is the case, you will be notified.

As the duly authorized representative of the applicant I certify that the applicant:

1. Has the legal authority to apply for Federal assistance, and the institutional, managerial and financial capability (including funds sufficient to pay the non-Federal share of project costs) to ensure proper planning, management and completion of the project described in this application.

2. Will give the awarding agency, the Comptroller General of the United States, and if appropriate, the State, through any authorized representative, access to and the right to examine all records, books, papers, or documents related to the award; and will establish a proper accounting system in accordance with generally accepted accounting standard or agency directives.

3. Will establish safeguards to prohibit employees from using their positions for a purpose that constitutes or presents the appearance of personal or organizational conflict of interest, or personal gain.

4. Will initiate and complete the work within the applicable time frame after receipt of approval of the awarding agency.

5. Will comply with the Intergovernmental Personnel Act of 1970 (42 U.S.C. §§4728-4763) relating to prescribed standards for merit systems for programs funded under one of the nineteen statutes or regulations specified in Appendix A of OPM's Standard for a Merit System of Personnel Administration (5 C.F.R. 900, Subpart F).

6. Will comply with all Federal statutes relating to nondiscrimination. These include but are not limited to: (a) Title VI of the Civil Rights Act of 1964 (P.L. 88-352) which prohibits discrimination on the basis of race, color or national origin; (b) Title IX of the Education Amendments of 1972, as amended (20 U.S.C. §§1681-1683, and 1685- 1686), which prohibits discrimination on the basis of sex; (c) Section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. §§794), which prohibits discrimination on the basis of handicaps; (d) the Age Discrimination Act of 1975, as amended (42 U.S.C. §§6101-6107), which prohibits discrimination on the basis of age; (e) the Drug Abuse Office and Treatment Act of 1972 (P.L. 92-255), as amended, relating to nondiscrimination on the basis of drug abuse; (f) the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970 (P.L. 91-616), as amended, relating to nondiscrimination on the basis of alcohol abuse or alcoholism; (g) §§523 and 527 of the Public Health Service Act of 1912 (42 U.S.C. §§290 dd-3 and 290 ee-3), as amended, relating to confidentiality of alcohol and drug abuse patient records; (h) Title VIII of the Civil Rights Act of 1968 (42 U.S.C. §§3601 et seq.), as amended, relating to non- discrimination in the sale, rental or financing of housing; (i) any other nondiscrimination provisions in the specific statute(s) under which application for Federal assistance is being made; and (j) the requirements of any other nondiscrimination statute(s) which may apply to the application.

7. Will comply, or has already complied, with the requirements of Title II and III of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 (P.L. 91-646) which provide for fair and equitable treatment of persons displaced or whose property is acquired as a result of Federal or federally assisted programs. These requirements apply to all interests in real property acquired for project purposes regardless of Federal participation in purchases.

8. Will comply with the provisions of the Hatch Act (5 U.S.C. §§1501-1508 and 7324-7328) which limit the political activities of employees whose principal employment activities are funded in whole or in part with Federal funds.

9. Will comply, as applicable, with the provisions of the Davis-Bacon Act (40 U.S.C. §§276a to 276a-7), the Copeland Act (40 U.S.C. §276c and 18 U.S.C. §874), and the Contract Work Hours and Safety Standards Act (40 U.S.C. §§327- 333), regarding labor standards for federally assisted construction subagreements.

10. Will comply, if applicable, with flood insurance purchase requirements of Section 102(a) of the Flood Disaster Protection Act of 1973 (P.L. 93-234) which requires recipients in a special flood hazard area to participate in the program and to purchase flood insurance if the total cost of insurable construction and acquisition is $10,000 or more.

11. Will comply with environmental standards which may be prescribed pursuant to the following: (a) institution of environmental quality control measures under the National Environmental Policy Act of 1969 (P.L. 91-190) and Executive Order (EO) 11514; (b) notification of violating facilities pursuant to EO 11738; (c) protection of wetland pursuant to EO 11990; (d) evaluation of flood hazards in floodplains in accordance with EO 11988; (e) assurance of project consistency with the approved State management program developed under the Costal Zone Management Act of 1972 (16 U.S.C. §§1451 et seq.); (f) conformity of Federal actions to State (Clear Air) Implementation Plans under Section 176(c) of the Clear Air Act of 1955, as amended (42 U.S.C. §§7401 et seq.); (g) protection of underground sources of drinking water under the Safe Drinking Water Act of 1974, as amended, (P.L. 93-523); and (h) protection of endangered species under the Endangered Species Act of 1973, as amended, (P.L. 93-205).

12. Will comply with the Wild and Scenic Rivers Act of 1968 (16 U.S.C. §§1271 et seq.) related to protecting components or potential components of the national wild and scenic rivers system.

13. Will assist the awarding agency in assuring compliance with Section 106 of the National Historic Preservation Act of 1966, as amended (16 U.S.C. §470), EO 11593 (identification and protection of historic properties), and the Archaeological and Historic Preservation Act of 1974 (16 U.S.C. §§ 469a-1 et seq.).

14. Will comply with P.L. 93-348 regarding the protection of human subjects involved in research, development, and related activities supported by this award of assistance.

15. Will comply with the Laboratory Animal Welfare Act of 1966 (P.L. 89-544, as amended, 7 U.S.C. §§2131 et seq.) pertaining to the care, handling, and treatment of warm blooded animals held for research, teaching, or other activities supported by this award of assistance.

16. Will comply with the Lead-Based Paint Poisoning Prevention Act (42 U.S.C. §§4801 et seq.) which prohibits the use of lead based paint in construction or rehabilitation of residence structures.

17. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act of 1984.

18. Will comply with all applicable requirements of all other Federal laws, executive orders, re- gulations and policies governing this program.

SIGNATURE OF AUTHORIZED CERTIFYING OFFICIAL	TITLE Secretary
APPLICANT ORGANIZATION Executive Office of Health & Human Services	DATE SUBMITTED

SF-424B (Rev. 7-97) Back

Massachusetts

Public Comments on State Plan

Section 1941 of the Block Grant legislation stipulates that as a condition of the funding agreement for the grant, States will provide opportunity for the public to comment on the State Plan. States will make the mental health plan public in such a manner to facilitate comment from any person (including Federal or other public agency) during the development of the plan (including any revisions) and after the submission of the plan to the Secretary.

States should describe their efforts and procedures to obtain public comment on the plan on the plan in this section.

Public Comments on State Plan

The State Mental Health Planning Council, a comprehensive, 59-member body comprising all of the stakeholders with an interest in mental health services, has been the primary reviewer of the annual State Mental Health Plan and Implementation Report for many years. In addition to the Plan's review by the Council, DMH posts the Plan prominently on its internal and external websites and solicits and reviews all comments received. If necessary, the Plan is amended to reflect changes made as a result of this process.

II. SET-ASIDE FOR CHILDREN'S MENTAL HEALTH SERVICES REPORT

States are required to provide systems of integrated services for children with serious emotional disturbances(SED). Each year the State shall expend not less than the calculated amount for FY 1994.

Data Reported by:

State FY X **Federal FY _____**

State Expenditures for Mental Health Services

Calculated FY 1994	Actual FY 2007	Estimate/Actual FY 2008
$50,822,635	$72,155,334	$73,216,721

Waiver of Children's Mental Health Services

If there is a shortfall in children's mental health services, the state may request a waiver. A waiver may be granted if the Secretary determines that the State is providing an adequate level of comprehensive community mental health services for children with serious emotional disturbance as indicated by a comparison of the number of such children for which such services are sought with the availability of services within the State. The Secretary shall approve or deny the request for a waiver not later than 120 days after the request is made. A waiver granted by the Secretary shall be applicable only for the fiscal year in question.

III. MAINTENANCE OF EFFORT(MOE) REPORT

States are required to submit sufficient information for the Secretary to make a determination of compliance with the statutory MOE requirements. MOE information is necessary to document that the State has maintained expenditures for community mental health services at a level that is not less than the average level of such expenditures maintained by the State for the 2-year period preceding the fiscal year for which the State is applying for the grant.

MOE Exclusion

The Secretary may exclude from the aggregate amount any State funds appropriated to the principle agency for authorized activities of a non-recurring nature and for a specific purpose. States must consider the following in order to request an exclusion from the MOE requirements:

1. The State shall request the exclusion separately from the application;
2. The request shall be signed by the State's Chief Executive Officer or by an individual authorized to apply for CMHS Block Grant on behalf of the Chief Executive Officer;
3. The State shall provide documentation that supports its position that the funds were appropriated by the State legislature for authorized activities which are of a non-recurring nature and for a specific purpose; indicates the length of time the project is expected to last in years and months; and affirms that these expenditures would be in addition to funds needed to otherwise meet the State's maintenance of effort requirement for the year for which it is applying for exclusion.

The State may not exclude funds from the MOE calculation until such time as the Administrator of SAMHSA has approved in writing the State's request for exclusion.

States are required to submit State expenditures in the following format:

MOE information reported by:

State FY __X__ **Federal FY _____**

State Expenditures for Mental Health Services

Actual FY 2006	Actual FY 2007	Actual/Estimate FY 2008
$405,399,802	$422,806,122	$432,694,125

MOE Shortfalls

States are expected to meet the MOE requirement. If they do not meet the MOE requirement, the legislation permits relief, based on the recognition that extenuating circumstances may explain the shortfall. These conditions are described below.

(1). Waiver for Extraordinary Economic Conditions

A State may request a waiver to the MOE requirement if it can be demonstrated that the MOE deficiency was the result of extraordinary economic conditions that occurred during the SFY in question. An extraordinary economic condition is defined as a financial crisis in which the total tax revenues declined at least one and one-half percent, and either the unemployment increases by at least one percentage point, or employment declines by at least one and one-half percent. In order to demonstrate that such conditions existed, the State must provide data and reports generated by the State's management information system and/or the State's accounting system.

(2). Material Compliance

If the State is unable to meet the requirements for a waiver under extraordinary economic conditions, the authorizing legislation does permit the Secretary, under certain circumstances, to make a finding that even though there was a shortfall on the MOE, the State maintained material compliance with the MOE requirement for the fiscal year in question. Therefore, the State is given an opportunity to submit information that might lead to a finding of material compliance. The relevant factors that SAMHSA considers in making a recommendation to the Secretary include: 1) whether the State maintained service levels, 2) the State's mental health expenditure history, and 3) the State's future commitment to funding mental health services.

TABLE 1. List of Planning Council Members

Name	Type of Membership	Agency or Organization Represented	Address, Phone and Fax	Email(If available)
Aalto, Steve	Providers	Work, Inc.	1419 Hancock Street Quincy,MA 2171 PH:617-691-1702 FAX:	
Belluardo-Crosby, Mark	Providers	Class, Inc.	1 Parker Street Lawrence,MA 01843 PH:617-788-1027 FAX:	
Boley, Ellen	Consumers/Survivors/Ex-patients(C/S/X)	MDDA; NAMI-Mass	1520 Ocean Street 2-34 Marshfield,MA 2050 PH:781-500-9163 FAX:	
Cabral, Rep. F.D. Antonio	State Employees	Other	Massachusetts House of Representatives State House - Room 22 Boston,MA 2133 PH:617-722-2140 FAX:	
Carey, Bernard J.	Family Members of adults with SMI	Massachusetts Association for Mental Health	130 Bowdoin Street Boston,MA 2108 PH:617-742-7452 FAX:	berncarey@aol.com
Carter, Cornelius Curtiss	Others(not state employees or providers)	Multicultural Advisory Committee	130 Dartmouth Street - #1202 Boston,MA 2116 PH:617-424-1918 FAX:	

Name	Type of Membership	Agency or Organization Represented	Address, Phone and Fax	Email(If available)
Chamberlin, Judi	Consumers/Survivors/Ex-patients(C/S/X)	National Empowerment Center	67 Magnolia Street Arlington,MA 2474 PH:781-777-1154 FAX:	madpride@aol.com
Chambers, Valeria	Consumers/Survivors/Ex-patients(C/S/X)	Consumers of Color Peer Networking Project-M*Power	70 St. Botolph Street #818 Boston,MA 2116 PH:617-424-9665 FAX:	
Chappell, John	State Employees	Vocational Rehabilitation	27 Wormwood Street Boston,MA 2110 PH:617-204-3620 FAX:	
Cimini, Jessica	Providers	SEE Coalition; Bay Cove Human Services	66 Canal Street Boston,MA 02114 PH: FAX:	
Cone, Ph.D., J.D., Patricia	State Employees	Criminal Justice	3 Center Plaza #520 Boston,MA 2108 PH:617-788-6550 FAX:	
Daitch, Deborah	Family Members of Children with SED		87 Pine Street Norton,MA 02766 PH: FAX:	

Name	Type of Membership	Agency or Organization Represented	Address, Phone and Fax	Email(If available)
Delman, Deborah	Consumers/Survivors/Ex-patients(C/S/X)	Transformation Center	98 Magazine Street Roxbury,MA 2119 PH:617-442-4111 FAX:	
Delman, Jon	Consumers/Survivors/Ex-patients(C/S/X)	Consumer Quality Initiatives, Inc.	132 Kemble Street Roxbury,MA 2119 PH:617-427-0505 FAX:	
DiGravio, Vic	Others(not state employees or providers)	Mental Health & Substance Abuse Corporations of Massachusetts, Inc.	251 W. Central Street Suite 21 Natick,MA 1760 PH:508-647-8385 FAX:	
Dulchinos, Peter	Family Members of adults with SMI	Statewide Advisory Council	17 Spaulding Road Chelmsford,MA 1824 PH:978-256-5256 FAX:	
Eisman, Ed.D., Elena	Others(not state employees or providers)	Massachusetts Psychological Association	195 Worcester Street #303 Wellesley,MA 2481 PH:781-263-0080 FAX:	
Festa, Michael	State Employees	Other	Executive Office of Elder Affairs One Ashburton Place - 5th Floor Boston,MA 2108 PH:617-222-7420 FAX:	

Name	Type of Membership	Agency or Organization Represented	Address, Phone and Fax	Email(If available)
Fields, Suzanne	State Employees	Medicaid	600 Washington Street Boston,MA 02111 PH:617-348-5101 FAX:	
Finn, Joseph	Others(not state employees or providers)	Massachusetts Housing & Shelter Alliance	PO Box 120070 Boston,MA 2112 PH:617-367-6447 x14 FAX:	
Fleischner, Robert	Others(not state employees or providers)	Center for Public Representation	22 Green Street Northampton,MA 1060 PH:413-586-6024 FAX:	
Gottlieb, Lawrence	Providers	Eliot Community Services	186 Bedford Street Lexington,MA 2420 PH:781-734-2025 FAX:	
Gregorio, Mary	Providers	U.S. Psychosocial Rehab Association/Center House, Inc.	31 Bowker Street Boston,MA 2114 PH:617-788-1002 FAX:	
Gurland, Lisa	State Employees	Other	Department of Public Health 250 Washington Street Boston,MA 2108 PH:(617) 624-5294 FAX:	

Name	Type of Membership	Agency or Organization Represented	Address, Phone and Fax	Email(If available)
Hadley, Phil	Family Members of adults with SMI	NAMI-Mass	400 West Cummings Park #6650 Woburn,MA 1810 PH:781-938-4048 FAX:	
Harvey, Marjorie	Others(not state employees or providers)	Statewide Advisory Committee	80 Park Street #23 Brookline,MA 2446 PH:617-735-9477 FAX:	
Hughes, Don	Providers	Riverside Community Care	450 Washington Street Dedham,MA 2026 PH:781-329-0909 FAX:	
Jackson, M.D., Anthony	Others(not state employees or providers)	New England Council of Child & Adolescent Psychiatry	31 Woodlawn Avenue Needham,MA 2492 PH:781-449-2512 FAX:	
Lambert, Lisa	Family Members of Children with SED	Parent/Professional Advocacy League	59 Temple Place #664 Boston,MA 2111 PH:617-542-7860 FAX:	
Laski, Frank	Others(not state employees or providers)	Mental Health Legal Advisors Committee	399 Washington Street Boston,MA 2108 PH:617-338-2345 x23 FAX:	

Name	Type of Membership	Agency or Organization Represented	Address, Phone and Fax	Email(If available)
Lawrence, Pat	Family Members of adults with SMI	NAMI-Mass	8 Elliot Road Lynnfield,MA 1940 PH:781-334-5756 FAX:	
Lewis, Nancy Blake	Family Members of adults with SMI	Refuah	15 Hemlock Terrace Randolph,MA 2368 PH:781-961-2815 FAX:	
Martinelli, Laurie	Others(not state employees or providers)	NAMI-Mass	400 West Cummings Park Suite 6650 Woburn,MA 1801 PH:781-938-4048 FAX:	
Matteodo, David	Others(not state employees or providers)	Massachusetts Association of Behavioral Health Systems	115 Mill Street Belmont,MA 2478 PH:617-855-3520 FAX:	
McClain, Angelo	State Employees	Social Services	Department of Children and Families 24 Farnsworth Street,MA 02210 PH:617-748-2000 FAX:	
McCloskey, David	Others(not state employees or providers)	Mass Shelter Providers Association	701 Main Street Worcester,MA 1610 PH:508-757-0103 FAX:	

Name	Type of Membership	Agency or Organization Represented	Address, Phone and Fax	Email(If available)
McCrory, M.D., Dennis	Others(not state employees or providers)	Friends of the Psychaitrically Disabled	6 Ridge Avenue Newton Center,MA 2459 PH:617-471-9990 FAX:	
McGuirk, Jo Ann	State Employees	Housing	One Cambridge Street #300 Boston,MA 2114 PH:617-573-1301 FAX:	
McWade, Matthew	Consumers/Survivors/Ex-patients(C/S/X)	Transformation Center	98 Magazine Street Roxbury,MA 2119 PH:617-442-4111 FAX:	
Medeiros, Lauri	Family Members of Children with SED	Mass Families Organizing for Change	94 Edward Street Medford,MA 2155 PH:617-605-7404 FAX:	
Mikula, Joan	State Employees	Mental Health	25 Staniford Street Boston,MA 2114 PH:617-626-8086 FAX:	
Mittnacht, Marcia	State Employees	Education	350 Main Street Malden,MA 2148 PH:781-338-3388 FAX:	

Name	Type of Membership	Agency or Organization Represented	Address, Phone and Fax	Email(If available)
Nemens, Kate	Others(not state employees or providers)	Mental Health Legal Advisors Committee	399 Washington Street 4th Floor Boston,MA 02108 PH:617-338-2345 FAX:	
O'Leary, Tim	Others(not state employees or providers)	Massachusetts Association for Mental Health	130 Bowdoin Street Boston,MA 2108 PH:617-742-7452 FAX:	
Page-Thompson, Susan	Family Members of Children with SED	South Shore Mental Health	54 Sedgewick Drive Scituate,MA 2066 PH:617-479-0356 FAX:	
Pond, Andrew	Others(not state employees or providers)	Massachusetts Council of Human Service Providers, Inc.	Justice Resource Institute 545 Boylston Street, 7th Floor Boston,MA 2116 PH:617-450-0500 FAX:	
Reeh, Gailanne	Others(not state employees or providers)	Arbour Associates, Inc.	15 Court Square #1050 Boston,MA 2108 PH:617-227-8829 FAX:	
Roderick, MSW, Mary	Others(not state employees or providers)	Massachusetts Association of Social Workers	53 Hillside Avenue Bedford,MA 1730 PH:617-484-0193 FAX:	

Name	Type of Membership	Agency or Organization Represented	Address, Phone and Fax	Email(If available)
Rose-Jacobs, Ruth	Family Members of Children with SED	Boston University School of Medicine & Boston Medical Center	91 East Concord Street Room 5106 Boston,MA 2118 PH:617-414-5480 FAX:	
Sheehan, Beverly	Others(not state employees or providers)	Massachusetts Psychiatric Society	40 Washington Street Wellesley,MA 2181 PH:781-237-8100 FAX:	
Smith, Duane F.	Family Members of Children with SED	Mass Families Organizing for Change	54 Mason Street Worcester,MA 1610 PH:508-667-6764 FAX:	
Stein, Reva	Others(not state employees or providers)	Massachusetts Clubhouse Coalition	15 Vernon Street Waltham,MA 2453 PH:781-788-8803 FAX:	
Talkov, Barbara	Others(not state employees or providers)	Children's League of Massachusetts	101 Tremont Street Suite 1000 Boston,MA 02108 PH:617-695-1991 FAX:	
Trachtman, Howard	Consumers/Survivors/Ex-patients(C/S/X)	Boston Resource Center	c/o Solomon Carter Fuller DMH Suite 516 Boston,MA 2118 PH:617-305-9976 FAX:	

Name	Type of Membership	Agency or Organization Represented	Address, Phone and Fax	Email(If available)
Tucker, Senator Susan	State Employees	Other	Massachusetts Senate State House-Room 416 A Boston,MA 2133 PH:617-722-1612 FAX:	
Vickery, Sandra	Others(not state employees or providers)	Councils on Aging	PO Box 806 Monument Beach,MA 2553 PH:508-759-0653 FAX:	
Weinstein, LMHC, Chuck	Providers	Tri-City Mental Health Center	173 Chelsea Street Everett,MA 2149 PH:781-388-6292 FAX:	
Whitman, Ph.D., Anne	Consumers/Survivors/Ex-patients(C/S/X)	Cole Resource Center/McLean Hospital	4 Dana Place Cambridge,MA 2138 PH:617-855-3298 FAX:	
Willett, John D.	Family Members of Children with SED		14 Cottage Street Apt. C Pepperell,MA 1463 PH:978-858-4462 FAX:	

TABLE 2. Planning Council Composition by Type of Member

Type of Membership	Number	Percentage of Total Membership
TOTAL MEMBERSHIP	59	[redacted]
Consumers/Survivors/Ex-patients(C/S/X)	8	[redacted]
Family Members of Children with SED	7	[redacted]
Family Members of adults with SMI	5	[redacted]
Vacancies(C/S/X and Family Members)	0	[redacted]
Others(not state employees or providers)	21	[redacted]
TOTAL C/S/X, Family Members and Others	41	69.49%
State Employees	11	[redacted]
Providers	7	[redacted]
Vacancies	0	[redacted]
TOTAL State Employees and Providers	18	30.51%

Note: 1) The ratio of parents of children with SED to other members of the Council must be sufficient to provide adequate representation of such children in the deliberations of the Council, 2) State Employee and Provider members shall not exceed 50% of the total members of the Planning Council, and 3) Other representatives may include public and private entities concerned with the need, planning, operation, funding, and use of mental health services and related support services. 4) Totals and Percentages do not include vacancies.

Massachusetts

Planning Council Charge, Role and Activities

State Mental Health Planning Councils are required to perform certain duties. If available, a charter or a narrative summarizing the duties of the Planning Council should be included. This section should also specify the policies and procedures for the selection of council members, their terms, the conduct of meetings, and a report of the Planning Council's efforts and related duties as mandated by law:

reviewing plans and submitting to the State any recommendations for modification
serving as an advocate for adults with serious mental illness, children with a severe emotional disturbance, and other individuals with mental illnesses or emotional problems,
monitoring, reviewing, and evaluating, not less than once each year, the allocation and adequacy of mental health services within the State.
the role of the Planning Council in improving mental health services within the State.
<STRONG>In addition to the duties mandated by law, States should include a brief description of the role of the Planning Council in the State's transformation activities that are described in Part C, Section II and Section III. </STRONG>

THE STATE MENTAL HEALTH PLANNING COUNCIL

The State Mental Health Planning Council is a standing committee of the Mental Health Advisory Council (MHAC) to the Massachusetts Department of Mental Health. The MHAC, established by statute (MGL c.19, section 11) and regulation (104 CMR 26.04 [4]) consists of 15 individuals appointed by the Secretary of the Executive Office of Health and Human Services to "advise the commissioner on policy, program development and the priorities of need in the Commonwealth for comprehensive programs in mental health." The Council does not have its own set of bylaws. All members of the Planning Council are nominated and appointed by the MHAC and include consumers, family members of adults and children, legal and program advocates, providers, other state agencies, mental health professionals and professional organizations, legislators, representation from state employee unions and members of racial, cultural and linguistic minority groups. The Council has recently expanded the membership of parents of children with serious emotional disturbance. DMH provides staff to the Council.

Many members of the Planning Council are also involved in locally based participatory planning processes and with other advocacy groups. As issues arise, smaller groups function as sub-committees of the Council, with membership that includes individuals on the Planning Council as well as other interested persons. These issues include the mental health needs of elders, children and adolescents, young adults, cultural/linguistic minorities and consumer-directed activities. These sub-committees meet regularly to advocate for the needs of the individuals they represent, advise DMH on policy issues, and participate in the planning and implementation of new initiatives.

Elder Mental Health Issues

The Elder Coalition, a sub-committee of the Planning Council, is made up of senior leaders from DMH, the Executive Office of Elder Affairs (EOEA), the Department of Public Health (DPH), representatives from local provider coalitions across the state, and statewide aging and mental health trade associations. This group is focused on the needs and concerns around serving elders and has a history of success in completing projects directed at systems improvement. These projects include publishing a guide on elder services, improving access to emergency services through provider trainings, and understanding the strengths and weaknesses of the nursing home screening system in an effort to divert admissions of those with a history of mental illness.

The group is in the process of setting its priorities for the next year and revisiting its membership and governance. Some of the priority areas include:

- Conducting a statewide needs assessment of mental health and substance abuse services for older adults;
- Addressing stigma;
- Improving state and federal interagency coordination;
- Integrating medical and behavioral health/substance abuse services; and
- Supporting the creation of the Older Adults Suicide Prevention Plan by the Department of Public Health.

Child/Adolescent Issues

Although there are now several children's mental health advocacy groups, the Professional Advisory Committee on Children's Mental Health (PAC) continues to be unique in its' broad approach to children's mental health. It has continued to advocate for high quality, easily accessible mental health services in an easy-to-navigate system. During the past year the PAC reviewed An Act Improving and Expanding Behavioral Health Services for Children in the Commonwealth. The bill, as filed, was a comprehensive piece of legislation created by a coalition, which sought to address issues ranging from insurance parity to pre-school mental health services. The PAC made detailed recommendations about several sections of the bill, many of which were accepted. The Governor signed a final version of the bill, an Act Relative to Children's Mental Health, in late August. The PAC met with State Senator Karen Spilka, Chair of the Joint Committee on Children, Youth, Families and Disabilities, who has filed legislation to reform the CHINS program (Child in Need of Services) and discussed ways to improve the bill and build on current system strengths. Finally, the PAC has supported funding for the initial stages of the Children's Behavioral Health Initiative.

In addition to its work on specific items, the PAC continues to serve as an information-sharing forum for its members and thus promotes coordinated advocacy. It held a joint meeting with the newly appointed Commissioners of the Departments of Children and Families and Mental Health where each talked about departmental goals and priorities, the expected impact of the implementation of the Rosie D remedy on their agencies, and the opportunities for promoting integrated service delivery.

Youth Development Committee

The Youth Development Committee (YDC) was organized in 2002 to focus on transition age programming (defined as those individuals between the ages of 16 and 25) and to create a voice for youth. Membership includes young adults as co-chairs, parents, transition experts and other professionals. This committee has met monthly and continues to expand its membership and re-establish priorities. Designated Area Point Persons report on progress related to supported employment, housing, and transition age youth case management. Statewide trainings for staff in SFY08 included Motivational Interviewing, Psychiatric Rehabilitation, and a Practical Application Training Series (PATS) which served as case consultations, particularly on the topics of self-injurious behavior, problematic sexual behavior, and overcoming risk-taking. A collaborative effort between the YDC and The Home for Little Wanderers' *Academic Support for College and Life Program* (ASCL) at Pine Manor College (a college and life-skills preparatory program) was created to include DMH young adult females. The YDC is submitting a policy application focusing on education and employment for the National Policy Academy on "Developing Systems of Care for Youth and Young Adults with Mental Health Needs Who Are Transitioning to Adulthood, and Their Families."

Employment Issues

On August 30, 2006, the Planning Council created a sub-committee on Employment because a significant number of Council members believed that an effort

should be made to make employment, including self-employment and volunteer opportunities, a central part of the fabric of the DMH delivery of care system. Council members believed that DMH and every DMH client, provider, case manager, clinician, and program should understand that employment is just as critical to recovery as treatment, housing, and peer support. Because the reprocurement of virtually all DMH contracted services was expected to commence in the next 18 months, the sub-committee prepared a report on employment, outlining a series of recommendations for principles or standards to be included in each of the DMH reprocurement documents. This report was adopted by the Council.

In SFY08, the Executive Office of Health and Human Services (EOHHS) initiated an effort to integrate employment services across all of the human service agencies, including DMH. EOHHS issued a Request for Information (RFI) to gain stakeholder input as it began the planning process for this initiative. The Sub-committee on Employment prepared and filed a formal response to the RFI, which included the recommendation contained in the Report adopted by the full Planning Council in April 2007.

The Sub-committee was represented and participated in a panel discussion on supported employment at a statewide conference on employment issues for the disabled and low-income communities on October 23, 2007.

In May 2008, DMH issued an RFI that contemplated a restructuring of its community based program models, including purchasing methods, performance measurements and rate determinations. The response date for the RFI is July 31, 2008. The sub-committee drafted a response to the RFI, which was presented and approved at the Planning Council meeting on July 15, 2008.

Multicultural Advisory Committee

The Multicultural Advisory Committee was accepted as a sub-committee of the Planning Council in April 2007. Two members of the sub-committee also recently joined the Planning Council. The sub-committee monitored the collection of client demographic data as a performance measure for the 2005-2007 State Plan. Ninety-five percent of clients are currently identified by race and ethnicity in the DMH's Mental Health Information System. Additionally, a quantitative analysis comparing census data and DMH service enrollment based on race and Hispanic or Latino origin was completed.

The sub-committee also worked with DMH's Office of Multicultural Affairs (OMCA) to produce three system recommendations on diverse workforce development, a promising mental health service model, and interpreter services. The Multicultural Advisory Committee has expanded its advisory role to other groups within DMH. For example, committee members are now represented in the State Mental Health Planning Council, Children's Behavioral Health Advisory Council and State Advisory Council.

TransCom

TransCom (the Transformation Committee) was established in 2004 to guide the work of the Mental Health System Transformation Grant funded by the Centers for Medicare and Medicaid Services (CMS). TransCom became a sub-committee of the Planning Council in SFY07. This committee brings together a diverse group of individuals and organizations working to establish a "flexible peer-driven infrastructure

across the state that will support recovery-oriented services and activities" and to "foster the development, promotion and coordination of innovative recovery-oriented best practices." TransCom celebrated the successful end of its three-year grant with a statewide conference "Working Side by Side for Recovery" in September 2007, attended by 250 people. In addition, TransCom developed "Peers as Valued Workers: A Massachusetts Roadmap for Successfully Integrating Peer Specialists and Peer Support Workers into the Public Mental Health System," which was presented to the DMH Commissioner. TransCom members committed themselves to continue working as a group on system transformation following the end of federal funding.

The Planning Council reviews the Department's State Plan, monitors its implementation and advocates regarding mental health system issues. The Council met on November 7, 2007, reviewed and unanimously approved the Fiscal Year 2007 Adult and Child/Adolescent Implementation Report. The Council also received an update on the Block Grant Peer Review session, prepared for their initial meeting with newly appointed Commissioner Leadholm, and planned meeting topics for the remainder of the fiscal year. The Council meeting on February 29, 2008 focused on child, adolescent and transition age youth issues, including a presentation on Rosie D and updates from the PAC and YDC sub-committees and the DMH Child/Adolescent division. The Council met on July 9, 2008 during which the FY2009-2011 State Plan was reviewed and unanimously approved. The Council also focused on elder mental health issues with a presentation and conversation with Secretary Festa of the Executive Office of Elder Affairs (EOEA) and the Elder Coalition sub-committee. In addition, the Council viewed a video prepared by the YDC, approved the Employment sub-committee's response to the DMH RFI on community based program models, and discussed the Family Options program, an innovative program providing case management services to families of parents with mental illness. As is customary at Planning Council meetings, Commissioner Leadholm and other members of DMH senior leadership were in attendance.

The Planning Council and its sub-committees provide a strong and ongoing voice for recovery and resiliency. The Council has made significant contributions in identifying particular domains needing transformation in the mental health system in Massachusetts. In addition, the Council and sub-committees have played an active role in planning many of the transformation efforts occurring in the Commonwealth. In particular, the Youth Development Committee has played a major role in organizing the voice of youth and collaborating with other key stakeholders in facilitating systems change. The Elders sub-committee continues to advance interagency collaboration between DMH and the Executive Office of Elder Affairs and their community partners. TransCom has played an integral role in advancing the development of a peer-driven infrastructure. The Employment sub-committee has developed and promoted a set of recommendations on promoting employment within DMH funded services. The Multicultural Advisory Committee participates in the monitoring of data to ensure access and culturally appropriate service delivery, and the Professional Advisory Committee on Children's Mental Health plays a key role in identifying gaps and ensuring that state agency and legislative efforts promote coordinated service delivery for families.

Massachusetts

Adult - Overview of State's Mental Health System

Adult - A brief description of how the public mental health system is currently organized at the State and local levels, including the State Mental Health Agency's authority in relation to other State agencies.

Overview of State's Mental Health System

Demographic Data

Massachusetts is a relatively small, industrial state with a net land area of 7,838 square miles and an average of 821 people per square mile. In 2006, it had a population of 6,437,193, a 1.4 percent increase over 2000, and ranks 13th in population and 45th in area among the states. More than half of the total population lives in the Greater Boston area. The state is 190 miles, east to west, and 110 miles, north to south, at its widest parts. According to the 2005 American Community Survey, 83.4 percent of the population was white, 5.9 percent African-American, .2 percent Native American, 4.7 percent Asian, 1.4 percent multiracial and 7.9 percent Hispanic. In recent years, there have been significant increases in immigrants and refugees from Southeast Asia, Central America, the Caribbean Islands and the former Soviet Union.

Although there are some towns in the western, central and southeastern (Cape Cod and offshore islands) parts of the state that are not attached to a Metropolitan Statistical Area, more than 75 percent of the population in DMH's Western and Central Massachusetts Areas are attached to identified urban centers. Each of the DMH local service sites has at least one town or incorporated city with a population greater than 15,000 that is considered the center of economic activity for the area. None of the local service sites has a population density below 100 people per square mile. As a result of this demographic profile, DMH does not have an official definition of "rural" or a separate division or special policies for adults, children or adolescents who reside in the less densely populated areas of the state. However, access to services in these areas continues to pose a challenge to Area planners and providers.

Historical Perspective on Mental Health Care: a Mission Evolves

Massachusetts has been a leader in caring for people with mental illness since it built the first public asylum in America. The Worcester State Hospital opened in 1833, serving as a model that other states soon followed. Over the next century, Massachusetts established a network of public hospitals, responding to needs as they arose. The Community Mental Health Centers Act of 1963, signed by President John F. Kennedy, espoused treating people with mental illness locally, rather than in large isolated state hospitals, and led to the construction of federally funded community mental health centers across the country, including several in Massachusetts.

Mental health care reform in Massachusetts has grown and changed since 1966, when the Legislature enacted the Comprehensive Mental Health and Retardation Services Act. Its purpose at the time was to decentralize DMH and set up a network of services within each community so that people could receive help close to their homes.

The process to increase the availability and quality of community programs was enhanced in 1978 when the Brewster consent decree was initiated. The consent decree asserted the right of mentally disabled persons in the Western Massachusetts Area to receive care in the least restrictive setting. It signaled a shift in the locus of treatment from institutional to community settings and aimed to reduce the Northampton State Hospital census. As a result, significant resources were directed to this DMH Area to implement the decree, accomplished through contracts with local providers. It became a

model for community-based service delivery statewide. DMH was disengaged from the consent decree in 1992. In 1984, Executive Order 244 prohibited children and adolescents (under 19) from being treated on adult inpatient wards of state hospitals and led to the creation of new residential prototypes and the privatization of most care for children under 19. On June 22, 2000, Governor Cellucci issued Executive Order 422, which replaces Executive Order 244 and allows placement of a 17 or 18 year old on an adult inpatient unit of a state-operated hospital or community mental health center when:

- A judge has issued an order for commitment to a mental health facility;
- An individual has been committed to the Department of Youth Services and DMH has determined that placing the individual on an adolescent unit would create a likelihood of serious harm to the person or others and/or the individual is in need of stricter security than is available on an adolescent mental health unit.

As a result of changes undertaken since 1991, the state hospital census in Massachusetts has dropped drastically from 23,000 in the 1950's to approximately 800 in 2008. This significant reduction occurred with the closure of four adult state hospitals and the only state-operated inpatient facility for children under age 14 between 1992 and 2003. Funds saved from the hospital closures were redirected into a variety of innovative and community-based programs. In February 2004, DMH presented a plan to the Legislature which proposed further downsizing and restructuring of the DMH extended stay adult inpatient system. The final report, prepared by the Facility Feasibility Commission, has led to further community expansion and the approval of a bond bill to consolidate two of the oldest hospitals and replace them with a new state-of-the-art psychiatric facility. This new facility will provide an optimal environment of care that is respectful and dignified, and that supports recovery and shorter lengths of stay so that individuals can return to productive lives in the community.

In July 1999, DMH issued the last section of its revised code of regulations, thus providing the general public and vendors who do business with DMH an up-to-date interpretation of the statutes that pertain to mental health. These new regulations recognize that many of the services now delivered to clients are contracted, rather than state-operated, and appropriately eliminated many burdensome requirements. The regulations outline DMH's authority, mission and organizational structure, citizen participation, licensing and operational standards for inpatient facilities (DMH-operated and other licensed inpatient facilities) and community programs, and standards for service planning, fiscal administration, research, investigation procedures, and designation and appointment of professionals to perform certain statutorily authorized activities. An additional chapter was added to DMH's regulations in January 2001 that codified the requirements for conducting Criminal Offender Record Checks on potential employees, trainees and volunteers of DMH or its vendor agencies.

Medicaid Managed Care

In 1992, the Commonwealth received one of the first waivers in the country to develop a behavioral health care carve-out program. This statewide program manages the behavioral health care program for those MassHealth recipients, including DMH clients who are also MassHealth recipients, enrolled in the Primary Care Clinician Program (PCCP). As the State Mental Health Authority, DMH worked with the Division

of Medical Assistance (DMA), at the time a stand-alone division, to develop the Request for Responses (RFR) for the procurements and participated actively in selecting the vendors to manage the behavioral health managed care program. The RFR forms the basis of the contract between DMA, now MassHealth, and its key Mental Health/Substance Abuse vendor. The vendor works closely with both DMH and MassHealth to ensure compliance with the current contract which includes an array of program standards, clinical criteria and protocols, policies, performance incentives and other purchasing specifications to ensure that both the MassHealth Behavioral Health Unit (MHBHU) and the vendor maintain the quality of care that DMH had previously been able to assure through its own acute units and emergency service program contracts.

As a result of the change to create a carve-out, DMH became the provider primarily of extended stay inpatient services and continuing care community-based services. DMH terminated its contracts with the former acute "replacement" inpatient units and emergency service programs, which became part of the vendor's network. However, DMH continues to operate 16-bed acute inpatient units at three of its CMHCs and accepts a limited number of acute admissions at other CMHCs in the Metro Boston Area, one of which is affiliated with a public health hospital.

DMH has developed a good working relationship with the Massachusetts Behavioral Health Partnership (MBHP), the vendor since 1996. DMH and MassHealth exchange data to ascertain the use of acute-care services by DMH clients that ultimately document DMH's financial obligation to MassHealth and forecast savings available for community investment. Monitoring the use of both acute and continuing care services allows DMH and MassHealth to target dollars and services where they are needed.

In October 2003, as part of the reorganization of the Executive Office of Health and Human Services (EOHHS), the Medicaid program (called MassHealth) was brought under the direct authority of the Secretary, as EOHHS became the Single State Agency for Medicaid. To assure continued high quality in the MassHealth Behavioral Health Program (MHBH), and to improve integration of that program with the services provided by DMH, the Secretary delegated programmatic responsibility for the MHBH to the DMH Commissioner. In 2007, a new administration reversed this decision and operational responsibility reverted to the Office of Medicaid; however, Medicaid and DMH are committed to a close working relationship on matters of policy for this shared population.

The Rosie D - EPSDT lawsuit filed against Medicaid is also changing the relationship between DMH and Medicaid for those under 21. According to the terms of the remedy, MassHealth will assume responsibility for both acute and continuing care community-based services (non-residential, non-inpatient) for enrollees from birth through 21 as access to these services is an entitlement.

It is also important to note that some DMH clients receive behavioral health services paid for by MassHealth through its four Managed Care Organizations (MCOs). This MCO network is currently being reprocured and there is a new emphasis on behavioral health services. In addition, some DMH clients with Medicare or commercial insurance access Medicaid behavioral health care on a fee for service basis.

DMH - The State Mental Health Authority

The DMH system of care emphasizes treatment, clinical services, rehabilitation and recovery. The central aim of service delivery is to integrate public and private services and resources to provide optimal community-based care and opportunities for clients. DMH works toward reducing the need for unnecessary hospitalization and out-of-home placement by improving integration of acute diversion with community support programs, including collaboration with the Department of Children and Families, MassHealth, MassHealth MCOs and its MH/SA vendor to assure an adequate and coordinated network of appropriate options. In addition, DMH has a well-established process in place that clearly defines the eligibility process, identifies the population to be served, and establishes a wait list for services. People eligible for DMH services are moved from waiting lists and into community programs as resources permit. The array of DMH-provided community services is described under Criterion I.

Defining the Target Population

As previously noted, DMH has had a policy defining "priority clients" since 1989. The policy was developed in response to the legislative mandate to narrow the service mission of DMH to adults with serious mental illness and children with serious emotional disturbance. However, with the signing of the Interagency Service Agreement (ISA) between DMH and DMA in July 1996 formalizing DMH's primary responsibility for continuing rather than acute care, DMH established a more consistent and reliable method of determining eligibility for its community services. Clinical teams of DMH eligibility determination specialists were identified and trained and functional assessment instruments were selected for use with adults and children. The eligibility determination process is being continuously evaluated and refined to ensure that clients do not fall through the cracks when transferring from the MassHealth managed behavioral health care vendor (acute care) to DMH (extended stay/continuing care) and to ensure that individuals who need DMH services get them. Changes made to the eligibility process in 2007 are expected to result in a more user-friendly and efficient entry into DMH's system of care for consumers and family members. The DMH Child/Adolescent division has used the CAFAS (Child and Adolescent Functional Assessment Scale) since July 1996 to assess functional impairment of children/adolescents applying for continuing care community services and have administered the CAFAS at the time of Individual Service Plan (ISP) renewal/reauthorization. However, beginning in late fall of 2008, the Division will begin to use the Child and Adolescent Needs and Strengths (CANS) for eligibility. Clients receiving case management will have the CANS completed as part of three month periodic reviews, and it will be administered at discharge from residential and inpatient programs. As the CANS was identified as the assessment tool for the Rosie D lawsuit, and is already being used for some Department of Children and Families clients, this will promote standardization of assessment and allow for cross-agency comparative analyses. Adults are assessed using the CERF-R (Current Evaluation of Risk and Functioning-Revised) - a DMH-designed assessment instrument. The CERF-R is used at the time of inpatient admission, three and six-month review, annually and at discharge. It is also used for adult clients receiving case management services in the community to assess each client's functioning at the time of ISP development and at least annually at the time of ISP renewal and reauthorization.

Organization of the Department of Mental Health

DMH is organized into six geographic Areas, each of which is managed by an Area Director. Each Area also has a full-time medical director, part-time child psychiatrist, full-time director of community services, and a full-time director of child/adolescent services, and is further subdivided into Local Service Sites. There are *29* Sites statewide, each of which is overseen by a Site Director/Case Management Supervisor. The Sites provide case management and oversee an integrated system of state and vendor-operated adult and child/adolescent mental health services. Most service planning, budget development, program monitoring, contracting, quality improvement and citizen monitoring services emanate from Site and Area offices.

The central office of DMH, located in Boston, has four divisions in addition to the Commissioner's office - Mental Health Services, Clinical and Professional Services, Management and Budget, and Legal. It coordinates planning, sets and monitors attainment of broad policy and standards, and performs certain generally applicable fiscal, personnel and legal functions, although the EOHHS reorganization centralized the management locus of certain functions to EOHHS, such as human resources, information technology and revenue. Some specialized programs, such as forensic mental health services, adolescent extended stay inpatient units, and child and adolescent intensive residential treatment programs are managed centrally by DMH. There are two Central Office human rights directors, one for adults and one for children and adolescents, and a director of consumer affairs. In addition, certain quality improvement activities are coordinated through central office. DMH allocates funds from its state appropriation and federal block grant to the Areas for both state-operated and contracted services, which include the three remaining state hospitals, five community mental health centers (CMHCs) with inpatient units, adult extended-stay units at two public health hospitals, contracted adult and adolescent extended-stay inpatient units and community-based services.

Each Area and Site has a citizen advisory board, appointed by the Commissioner and comprised of consumers, family members, professionals, interested citizens and advocates. They assess needs and resources and participate in planning and developing programs and services in their geographic domain. A Mental Health Advisory Council (MHAC), appointed by the Secretary of EOHHS and comprised of consumers, family members, professionals, interested citizens and advocates, receives and analyzes data pertaining to the entire system and advises the Commissioner on mental health policy and priorities. The State Mental Health Planning Council is established as a subcommittee of the MHAC. In addition, there is a statewide Human Rights Advisory Committee, and each hospital has a board of trustees appointed by the Governor and a trustee's seat on the Area board in the DMH Area where the hospital is located. Although not mandated by statute or regulation, there also is a Professional Advisory Committee on children's mental health, comprised of advocates, professionals, family members and state agency representatives, a Consumer Advisory Council and two advisory groups to the Office of Multicultural Affairs.

All of the state hospitals, CMHCs, adolescent inpatient units, and child and adolescent intensive residential treatment programs are accredited by the Joint Commission and certified by CMS (Center for Medicare and Medicaid Services). DMH has the statutory responsibility for licensing all non state-operated general and private

psychiatric inpatient units and adult residential programs in the state. Children's community residential programs are licensed by the Department of Early Education and Care.

Massachusetts

Adult - Summary of Areas Previously Identified by State as Needing Attention

Adult - A brief summary of areas identified by the State in the previous State plan as needing particular attention, including the significant achievements in its previous fiscal year.

Massachusetts

Adult - New Developments and Issues

Adult - New developments and issues that affect mental health service delivery in the State, including structural changes such as Medicaid waivers, managed care, State Children's Health Insurance Program (SCHIP) and other contracting arrangements.

Unmet Service Needs - Child

Access to and availability of services continues to be a high priority for DMH. DMH makes every effort to provide at least one community-based service to all child and adolescent clients and tracks this data as a performance indicator in the State Plan. However, the need for case management and residential support services remains greater than the current capacity. DMH's Mental Health Information System (MHIS) maintains data on DMH clients who are currently receiving case management and residential support services and those who are on waitlists for these services. Children who no longer need inpatient or other acute care, but who remain "stuck" in hospitals or other acute settings for lack of appropriate discharge plans are yet another indicator of the difficulty in accessing services. They also impede access to hospitalization for new admissions as beds are unavailable. MBHP reports weekly on the number of "stuck" kids to DMH, DCF and EOHHS.

DMH recognizes the ongoing need to reduce racial and ethnic disparities in the accessibility, availability and quality of mental health services. In the last several years, DMH has made significant efforts to ensure that demographic information in MHIS is accurate concerning age, gender, race, ethnicity and preferred language. DMH is currently analyzing data on race and ethnicity as a part of the annual consumer and family member satisfaction survey and the DMH eligibility/ineligibility and service enrollment study. Multicultural and disparities research has also become a required area of research for DMH's two Centers of Excellence. DMH is particularly interested in the sustainability of culturally and linguistically competent services and in demonstrating the outcomes of such services for culturally and linguistically diverse populations. DMH also continues to monitor MHIS data related to access and appropriateness of services offered to other underserved populations including: clients with co-occurring disorders, transition age youth and Deaf and Hard of Hearing clients.

A trauma-sensitive approach to treatment is needed throughout the DMH system. The Child/Adolescent Restraint Prevention Initiative has led to significant progress within the programs initially targeted for change, namely the inpatient facilities and intensive residential treatment programs. The work needs to expand to encompass community residential providers.

Children and adolescents with autism spectrum disorders and severe behavior problems continue to present a service challenge. The Department of Mental Retardation (DMR) has been charged with planning for youth up to age 18 along the autism spectrum. However, there remains a need for additional service resources.

Massachusetts

Adult - Legislative Initiatives and Changes

Adult - Legislative initiatives and changes, if any.

Legislative Initiatives and Changes

The Massachusetts legislature took several steps in this past session to improve access and quality of care for children and adults. Passage of *An Act Relative to Children's Mental Health* represents a victory for a broad coalition of mental health advocates. Many components of the initial comprehensive bill were passed this year, with advocates committed to returning next year to address unfinished business. The law creates some new requirements and establishes a legislative mandate for some current practices. Key provisions create a children's behavioral health research and evaluation council, require that DMH be consulted in the design and implementation of behavioral health services being planned by other EOHHS agencies, mandate multi-agency teams to address complex cases, require EOHHS to implement new policies regarding "stuck kids," and create a task force on behavioral health and public schools. Special education was addressed in a separate law which requires that the state adhere to its current standard of requiring transition planning to commence at age 14.

The state's current Mental Health Parity Law, which for adults afforded parity only for a specific list of "biologically based" disorders, was significantly expanded so that it will now include substance use disorders, eating disorders, post traumatic stress disorder and autism. The bill also gives the Commissioner of Mental Health the authority to approve any mental disorder in the DSM for inclusion under parity. In a separate measure, the Legislature has continued to include language in the MassHealth budget requiring approval by the Commissioner of DMH before any psychotropic drugs can be placed on the list of medications requiring prior approval. This has enabled DMH to apply clinical standards to this important area. A Health Care Cost Containment law expands the Department of Public Health's Loan Forgiveness program, initially covering only primary care physicians in underserved communities, to now include psychiatrists and should help address workforce issues.

In May 2008, Governor Patrick signed the Housing Bond Bill into law. This law reauthorized the Facilities Consolidation Fund (FCF) which provides financing assistance to developers creating housing for clients of the Department of Mental Health and the Department of Mental Retardation. In addition to providing $25 million in funding for the program, the law contains a provision for which DMH had long been advocating. This provision allows FCF funding to be given to "for-profit" housing development organizations in addition to long eligible non-profit organizations. DMH expects to obtain a greater volume of new, scattered-site apartments because of this provision. The legislature also renewed its bond authorization, originally given in 2007, for the construction of a new 320 bed state-of-the-art psychiatric facility to be located in the central part of the state. The facility will include 260 adult beds and 60 child and adolescent beds and is expected to be completed in 2011 or 2012.

An Act to Protect the Mentally Ill in Emergency Rooms addresses concerns about the quality of care delivered to individuals with mental illness in hospital emergency departments, an issue that has received both local and national attention. Evidence shows that people with mental illness do not always receive high quality care, delivered with

dignity and respect. The bill emerged from the mental health grassroots movement, led by the consumer group M-POWER, and would require the state Department of Public Health (DPH) to work with DMH to develop specific regulations governing psychiatric services in emergency departments. While the legislation did not pass this session, DPH and DMH have spearheaded a broad-based initiative to examine and implement best practices in emergency rooms and to develop increased opportunities to divert individuals in psychiatric crisis from emergency room admission.

Massachusetts

Adult - Description of Regional Resources

Adult - A brief description of regional/sub- State programs, community mental health centers, and resources of counties and cities, as applicable, to the provision of mental health services within the State.

Massachusetts

Adult - Description of State Agency's Leadership

Adult - A description of how the State mental health agency provides leadership in coordinating mental health services within the broader system.

Description of State Agency's Leadership

In recent years, DMH has taken on a significant leadership role in coordinating mental health services within the broader system. Through ongoing and strengthened relationships with other state agencies, provider and advocacy groups, and other stakeholders, DMH seeks to improve the quality of services for and ultimately the outcomes of those individuals needing and receiving mental health services.

DMH demonstrates leadership within the broader system in the following areas:

Research

To carry out its statutory research mission, DMH funds two Centers of Excellence; one in Clinical Neuroscience and Neuropharmacology (Harvard Medical School) and one in Behavioral and Forensic Sciences (University of Massachusetts Medical School). Both Centers are conceptualized as Public/Academic Liaisons, a model of interaction for clinical research championed by the Center for Mental Health Services. The Centers are structured independently with DMH and an accredited academic institution. They are expected to meet mutually agreed upon standards and to leverage DMH funds to procure outside research grants. The Centers provide general research assistance, as well as consultation to DMH-operated or contracted programs, and DMH Central Office, on request.

Last year, the two Centers of Excellence were re-contracted for an additional five-year period. The current contracts stipulate several important enhancements intended to ensure a closer working relationship between DMH and each Center, and between the two Centers. The enhancements include increased communications among all parties; a focus on multicultural research, especially in the area of eliminating disparities in services; a renewed focus on child, adolescent and family research; an emphasis on incorporating the perspectives of consumers and families in planning and implementing research; and the incorporation of a "Science to Service to Science" perspective in the Centers. The Deputy Commissioner for Clinical and Professional Services holds monthly meetings with representatives of the two Centers in order to ensure that these goals are being met.

The "Science to Service to Science" perspective is a direct response to the challenges identified in The President's New Freedom Commission Report, and the issues identified by the Institutes of Medicine. DMH is working collaboratively with the two Centers to identify promising research results that can be used to assist DMH in meeting its mission, and to generally increase the visibility of research as a practical tool throughout the service system.

Finally, as required by federal law and state regulation, DMH's Central Office Research Review Committee reviews and must approve all requests by researchers to use DMH clients, past or present, as research subjects. At any given time, there are about 100 research studies taking place within DMH facilities, and about 25 – 30 new studies are reviewed and approved each year.

Regulations

In April 2006, DMH promulgated its restraint and seclusion regulations. The previous regulations, which had not changed significantly since their initial issuance in the mid-1980's, acknowledged that restraint and seclusion would be used frequently and therefore focused on their safe and well-documented use. The 2006 version changed the

emphasis from use to prevention as demonstrated by the title of the regulations, "Prevention of Restraint and Seclusion and Requirements When Used." The prevention focus of the new regulations incorporates the six principles of the National Technical Assistance Center's training program on restraint prevention which has been provided on a wide scale both nationally and internationally.

The changes in DMH regulations are compatible with the Centers for Medicare and Medicaid Services (CMS) and The Joint Commission standards on restraint and seclusion, thus easing the burden on facilities (DMH state-operated facilities and DMH licensed facilities) subject to all three sets of requirements.

DMH collects statewide restraint and seclusion data from all licensed, state-operated and state-contracted inpatient facilities (adults, children and adolescents) and intensive residential treatment programs (children and adolescents). Through its licensing and contracting authority, DMH provides direction, technical assistance, clinical expertise and consultation on state-of-the-art practices designed to reduce the utilization of these high-risk interventions. Review of the facility's restraint data and a discussion of prevention, early intervention and pro-active planning efforts have been a focus of each two-year licensing visit and the more frequent contract monitoring visits. The DMH licensing division and Child/Adolescent Services division provide ongoing, as-needed consultation and assistance to these facilities and programs.

Child & Adolescent Restraint & Seclusion Initiative

DMH remains actively involved in a statewide initiative to prevent the use of seclusion and restraint in all psychiatric inpatient services in the Commonwealth. The effort began in 2001 with a focus on promoting strength-based care and reducing these coercive, high-risk procedures in child and adolescent acute and continuing care inpatient units and intensive residential treatment programs. By using DMH's contracting, licensing, and statutory authority, the collective teaching and practice change efforts organized through the initiative led to a significant statewide decline (-86%) in seclusion and restraint use. In addition, duration has decreased 67% and medication restraint has reduced 76%. Some units have stopped using seclusion and restraint, many programs have significantly reduced their use. The initiative was used as a template for a national curriculum to create violence-free and coercion-free treatment environments through NASMHPD's Office of Technical Assistance (OTA), and funded by the Center for Mental Health Services at SAMHSA. Several DMH staff were NTAC founding teaching faculty and continue to work with NASMHPD to advance this effort nationally and internationally. These staff members, along with NASMHPD's OTA, were awarded the NAMI Gloria Huntley award for their work on local and national efforts to change cultures of care and reduce coercive practices.

This year, DMH issued the second expanded edition of *"Creating Positive Cultures of Care,"* a comprehensive Resource Guide which has been sought after by several states, countries, and private organizations. New to this Resource Guide are Child and Family Roles in care and the Consumer Experience of coercive practice across the lifespan. These additions, in particular consumer roles, are helping DMH and others to form more creative partnerships and effective collaborations with youth and family to ensure services are youth-guided and parent-driven and ultimately responsive to their needs. Most recently, the Resource Guide has been shared with SAMHSA and will be

used as part of the Restraint Seclusion Strategic Planning session/meeting of the Matrix Workgroup in August 2008.

DMH will be expanding the initiative to child/adolescent community-based residential programs in the coming year. The summer of 2008 will be spent drafting a stratified roll-out plan based on varying the scope of implementation possibilities, subject to sufficient staffing and resources. Meeting with other child-serving agencies (child welfare and licensing) has reinforced and strengthened the intent to connect this effort to other youth-serving agencies as part of this expansion effort.

Adult Restraint and Seclusion Reduction/Elimination Initiative

In October 2004, Massachusetts was one of eight states to receive a State Incentive Grant (SIG) funded by SAMHSA through the National Association of State Mental Health Program Directors (NASMHPD). DMH has since implemented a system-wide initiative to reduce and eliminate the use of seclusion and restraint in its state-operated adult facilities. This involved a multi-layered process of facility preparation through increased training and data use to inform care. All ten state hospitals and community mental health centers adopted the Six Core Strategies© developed by the National Technical Assistance Center (NTAC) of NASMHPD. This adoption of guiding principles created a standardized, system-wide set of expectations while allowing each individual facility to formulate its own specific implementation plan. In September 2007, Commissioner Leadholm signed a new DMH Restraint/Seclusion Policy. In addition to a significant reduction in restraint episodes, number of affected persons and hours of restraints, the grant activities have also led to an unexpected level of culture change within the facilities.

Human Rights

DMH's Office of Human Rights is comprised of two directors -- one for adults and one for children and adolescents. Regulation and policy require Human Rights Officers and Human Rights Committees in public and private inpatient settings and in state-operated and contracted community programs. Additionally, there is a statewide Human Rights Advisory Committee that advises and assists the Commissioner in matters regarding the human and civil rights of clients served by DMH. In an effort to better integrate human rights principles and values in DMH operations, the Directors of Human Rights have increased their participation in major policy efforts (e.g. Restraint and Seclusion Reduction Initiative, Risk and Safety Management Taskforce in FY 2006 and FY 2007, and Informed Consent Policy in FY2008). . Through its human rights function, DMH is both a monitor and promoter of the use of the legal processes that exist pursuant to DMH regulation, state law and federal law to protect the rights of service recipients. DMH has developed a human rights handbook, human rights brochure for parents and children, and human rights videos for children and adolescents and for the deaf and hard of hearing. In previous years, DMH sponsored two annual human rights conferences, which were halted due to budget reductions. In the absence of these statewide conferences, the focus has shifted to smaller Area-based training with an emphasis on skill building for human rights personnel (i.e., Human Rights Officers/Coordinators/Committee members). A human rights training series is currently in development to meet the on-going training needs of community programs.

Collaboration between the Office of Human Rights and Staff Development has resulted in a more expansive annual review in human rights for DMH employees.

Suicide Prevention

As the State Mental Health Authority, DMH is engaged in statewide suicide prevention efforts in collaboration with the Department of Public Health (DPH) and the Massachusetts Coalition for Suicide Prevention. Intervention is an important aspect of suicide prevention and DMH continues to encourage the use of screening tools for depression in pediatric and adult primary care settings and is committed to improving the interface between providers of mental health and general physical health care. DMH and DPH are planning a training for community residential providers that will address facility safety, creating a milieu that reduces suicide attempts, and steps for coping with the aftermath of attempts or completions.

Forensic Mental Health Services

DMH maintains a Division of Forensic Mental Health (DFMH) that has a long history of providing forensic mental health services within inpatient facilities and to inmates leaving the correctional system. DFMH also provides forensic evaluations and case consultations to the juvenile and adult criminal courts through a statewide system of court clinics. These include evaluations of competence to stand trial, criminal responsibility, aid in disposition, and other evaluations as requested by Probation or ordered by the Court. In addition, court-ordered statutory forensic evaluations (such as evaluations of competence to stand trial, criminal responsibility, aid in sentencing and need for care and treatment of inmates) are provided on an inpatient basis throughout the Commonwealth. Juvenile Court evaluations also include assessments in child abuse and neglect proceedings as well as court-ordered evaluations in delinquency, Youthful Offender, and status offender cases. A specialized Child and Adolescent Forensic Team provide court-ordered evaluations for youth who have been committed by the Courts for an inpatient forensic examination.

DFMH maintains a statewide Forensic Transition Team (FTT) that provides community re-entry planning services to inmates with serious mental illnesses in preparation for discharge from county Houses of Correction and the Massachusetts Department of Corrections (DOC). FTT now also provides re-entry planning for delinquent youth with significant psychiatric challenges who are transitioning from placement at secure treatment facilities operated by the Department of Youth Services. FTT coordinates its work with re-entering adults and juveniles with Area-based care managers to provide continuity of care through psychosocial assessment, early engagement, consistent support and a well-monitored transition.

In order to fulfill its statutory obligation with respect to supervising medical and psychiatric services in the segregated units in DOC prisons, DMH coordinates a multi-disciplinary team that visits these units on a regular basis to help DOC ensure that inmates in those units receive appropriate medical, dental and psychiatric care. If requested to do so, DMH facilitates peer reviews with DOC staff after an inmate suicide or other adverse event, and DMH participated within the past year in a working group established by the Governor to review DOC medical and mental health services.

In FY 2007, the legislature awarded DFMH funding for “start up” grants to support implementation of five pre-arrest jail diversion programs. These grants were

awarded and a system of consultation and technical support to assist planning, implementation and program evaluation has been put into place. These grants have enabled the generation of data that will inform models of jail diversion in operation in Massachusetts.

DFMH also provides specialized assessment and intervention programs for specific populations. A program for persons with mental illness and problematic sexual behaviors (MIPSB) provides specialized clinical and risk management assessments to help inpatient treatment teams and community providers in working with persons with these specific difficulties, some of whom have also been charged and/or convicted of sexual offenses. The Mandatory Forensic Review (MFR) program provides a policy-based specialized risk assessment and management consultation prior to contact with the community and/or discharge from the hospital for inpatients with significant histories of physical violence or a history of commitment in a strict security setting. Additionally, DFMH serves as the DMH liaison for the Sexual Offender Registry Board (SORB) and the Criminal History Systems Board (CHSB), the state entity that maintains Massachusetts' arrest and court adjudication records. In this capacity DFMH accesses SORB and criminal history records for risk management purposes for DMH inpatient units, supports the completion of court-ordered forensic evaluations, and assists in resolving SORB registration obligations in individual cases when difficulties arise.

In partnership with the University of Massachusetts Medical School, DFMH provides a specialized training and certification program for clinicians who conduct court-ordered evaluations with juveniles or adults. Additionally, both adult and juvenile court clinics and inpatient forensic evaluation services serve as training sites for graduate students in social work and psychology as well as psychiatric residents from a variety of educational programs. DFMH oversees training of forensic psychology post-doctoral fellows and collaborates with other arms of DMH to provide oversight related to forensic psychiatry training. Many of the trainees have gone on to take positions within the public sector in Massachusetts and within the forensic mental health service system. DFMH also provides training on forensic mental health and risk management issues for DMH staff and contracted service providers who provide care on inpatient units and in the community.

Office of Multicultural Affairs

The Office of Multicultural Affairs (OMCA) has developed and completed two three-year Cultural Competence Action Plans (FY 2002-2007), placing DMH's mission of culturally and linguistically competent care into action. Major building blocks of systemic competence have been established, such as community partnerships, leadership development, service and standards development, education and training, information dissemination, data and research, and human resources development. Examples of accomplishments and activities of DMH under the leadership of OMCA include:

- OMCA collaborated with the Massachusetts Behavioral Health Partnership (MBHP) and the Mental Health and Substance Abuse Corporations of Massachusetts (MHSACM) in completing a performance incentive project to determine whether contractors met the needs of non-English speaking and culturally diverse Mass Health recipients and proposed recommendations to enhance network capacity. As a result of the project completion, a follow-up performance incentive project is currently in progress. This project focuses on the

evaluation of the prevalence of racial disparities in accessing appropriate behavioral health care and developing strategies to mitigate disparities.

- OMCA partnered with the Harvard Program in Refugee Trauma, Massachusetts Behavioral Health Partnership, UMass Medical School Office of Community Programs, Massachusetts Medical Society and DMH Western Mass Area Office in providing three statewide trainings on Healing the Wounds of Mass Violence: Assessment and Treatment of Refugees and Torture Survivors.
- Multicultural and disparities research became required areas of research for the two DMH Centers of Excellence, with dedicated staff. The planning of specific research topics is in progress.
- OMCA partnered with the Office for Refugees and Immigrants to identify the mental health needs of refugees and recommended solutions to reduce barriers to services.
- Each DMH Area organized a Multicultural / Diversity Committee. These committees developed and implemented their respective Area Cultural Competence Action Plans.
- OMCA provided 56 cultural competence consultations as well as information and referrals to DMH staff and providers.
- A Cultural Competence curriculum, "Integrating Culture in Practice" was developed. Sixteen trainings were completed with DMH and providers.
- A monthly tracking and utilization report of interpreter and translation services by DMH Areas and Sites, languages, number of clients and total number of encounters has been instituted.
- OMCA identified best practice models to increase accessibility and availability of culturally and linguistically appropriate services. Examples of some models are: bi-lingual and bi-cultural specialist teams; community health center mental health screening and early intervention program for refugees; coordinated family focus care for refugee children and families; and multicultural community education and outreach initiatives.
- DMH also created the C.L.A.S. (Culturally and Linguistically Appropriate Services) Award as one of the Commissioner's Distinguished Service Awards. It honors a person, a group of people, or a program, within DMH or outside DMH, whose work has demonstrated an outstanding commitment to cultural and linguistic competence and resulted in significant progress toward the elimination of health disparities by ensuring access to the highest quality of mental health care.

Parents with Mental Illness

As research shows that parental mental illness directly impacts the mental health of children, and that most adults who are parents consider that to be a key part of their identity, DMH began to ask information about clients' children and their custody status several years ago. The DMH adult eligibility application was modified several years ago to include questions about adults' Department of Children and Families involvement and DMH offers short-term services while eligibility is being reviewed. The newly revised application form asks all adults if they are parents, recognizing that assistance in parenting may be just as crucial for those who are not involved with the Department of

Children and Families. The Options Clubhouse hosts three projects related to parents with mental illness, including legal assistance for parents who are trying to maintain or regain custody of their children, and those who do not have custody of their children but still wish to have access to them, and a grant-funded project to provide wraparound services to families where there is parental mental illness. Recognizing the particular needs of transition age youth who are parenting, Options Clubhouse is now piloting an intervention for this age group using a parent coach and a peer mentor. At the request of the Youth Development Committee, DMH is focusing on transition-age youth who are pregnant and/or parenting and is conducting a needs assessment and developing a centralized directory of services that might be of assistance to this population.

Massachusetts

Child - Overview of State's Mental Health System

Child - A brief description of how the public mental health system is currently organized at the State and local levels, including the State Mental Health Agency's authority in relation to other State agencies.

DMH has chosen to integrate the adult and child narrative for this section of the plan for the following reasons. First, the Child and Adolescent Division of DMH resides within Program Operations at Central Office. New applicants who are age 18 and who meet adult eligibility criteria are entered as adults; if they do not meet adult criteria they may become eligible under the child/adolescent criteria. Individuals under the age of 19 may receive adult services when clinically appropriate as adults over the age of 19 may receive child and adolescent services when appropriate. Furthermore, DMH has placed significant emphasis on planning for transition age youth between the ages of 16 and 25. This age grouping encompasses both the child/adolescent and adult systems. Lastly, the Rosie D Class, as described in the Executive Summary, includes children up to age 21. DMH recognizes the need for its child, adolescent and young adult services to align with and complement Rosie D services.

Massachusetts

Child - Summary of Areas Previously Identified by State as Needing Attention

Child - A brief summary of areas identified by the State in the previous State plan as needing particular attention, including the significant achievements in its previous fiscal year.

Massachusetts

Child - New Developments and Issues

Child - New developments and issues that affect mental health service delivery in the State, including structural changes such as Medicaid waivers, managed care, State Children's Health Insurance Program (SCHIP) and other contracting arrangements.

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Massachusetts

Child - Legislative Initiatives and Changes

Child - Legislative initiatives and changes, if any.

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Massachusetts

Child - Description of Regional Resources

Child - A brief description of regional/sub- State programs, community mental health centers, and resources of counties and cities, as applicable, to the provision of mental health services within the State.

Massachusetts

Child - Description of State Agency's Leadership

Child - A description of how the State mental health agency provides leadership in coordinating mental health services within the broader system.

DMH has chosen to integrate the adult and child narrative for this section of the plan for the following reasons. First, the Child and Adolescent Division of DMH resides within Program Operations at Central Office. New applicants who are age 18 and who meet adult eligibility criteria are entered as adults; if they do not meet adult criteria they may become eligible under the child/adolescent criteria. Individuals under the age of 19 may receive adult services when clinically appropriate as adults over the age of 19 may receive child and adolescent services when appropriate. Furthermore, DMH has placed significant emphasis on planning for transition age youth between the ages of 16 and 25. This age grouping encompasses both the child/adolescent and adult systems. Lastly, the Rosie D Class, as described in the Executive Summary, includes children up to age 21. DMH recognizes the need for its child, adolescent and young adult services to align with and complement Rosie D services.

Massachusetts

Adult - Service System's Strengths and Weaknesses

Adult - A discussion of the strengths and weaknesses of the service system.

Service System's Strengths and Weaknesses

Massachusetts demonstrates a number of strengths which, woven together, represent the promise of a service delivery system organized around principles of recovery oriented, consumer and family-centered care. At the heart of these strengths is a commitment to fostering partnerships with other state agencies, advocates, consumers, family members and other key stakeholders. DMH benefits from a strong and growing infrastructure for consumer recovery and empowerment. This infrastructure has been strengthened by the formation of the Transformation Center, a statewide consumer-run technical assistance center. Family members of both children and adults have played a significant role in shaping the service system. Parents and family members participate in all policy and program development activities that are not strictly internal. DMH receives regular feedback on service issues through PAL, the Parent Professional Advocacy League, and from DMH funded parent support groups. There is also a strong and consistent provider presence within DMH's planning efforts.

Recognizing that collaboration is central to any transformative effort, DMH has engaged in several statewide initiatives that have demonstrated real change in the service system of Massachusetts. The Child/Adolescent Restraint Prevention Initiative and the Adult Restraint and Seclusion/Elimination Initiative have both brought about significant culture change in promoting a transformed environment based on recovery models in addition to accomplishing goals of reducing and preventing the practice of seclusion and restraint. The Readmission Collaborative has brought together consumers, family members, insurers and providers to reduce readmissions within acutecare psychiatric facilities.

DMH has also placed a significant focus on planning efforts for underserved populations. DMH's Office of Multicultural Affairs and the Multicultural Advisory Committee have demonstrated leadership and innovation in developing and achieving the goals outlined in the multi-year Cultural Competence Action Plans, and in building analysis of mental health care disparities into DMH's quality improvement activities. In recent years, DMH has increased services to Deaf and Hard of Hearing clients. DMH has also focused resources on strengthening the voice of and building an infrastructure for transition age youth, ages 16 through 25. In addition, DMH has partnered with groups of stakeholders to plan for the needs of parents with mental illness and for elders. Lastly, the DMH Homeless Initiative has joined with other community partners to leverage funds and provide clinical and residential services to support individuals in community-based housing.

Administrative, fiscal and programmatic challenges remain, as does a certain amount of fragmentation. DMH administers continuing care community and inpatient services. Most public acute-care inpatient and outpatient services are funded and overseen by MassHealth and its managed care entities, and more than half of DMH child and adolescent clients have at least part of their treatment paid for by their parent's private insurance. This separation in funding can make it difficult to integrate the clinical and fiscal components of service delivery that need to be in place for individuals with complex service needs. It impedes care coordination and is a barrier to early identification and delivery of timely follow up care. Current funding mechanisms also reimburse for services only to the identified client and thus are a barrier to family-focused

interventions which are needed by adults with mental illness who are parenting and for children and adolescents whose family members also need assistance. Problems in service access and coordination for children and adolescents are exacerbated by the differences in agency mandates, expected outcomes and staff expertise that make it challenging to deliver integrated services according to a single plan of care. These are key issues for the Children's Behavioral Health Initiative. All sectors of the service system are challenged by the ability to recruit and retain a qualified workforce, particularly for culturally and linguistically diverse populations. Reimbursements to providers have not kept pace with inflation or with salaries outside of human services, and have not covered the significant costs associated with information technology and quality improvement. As a result of these issues, access to care may be delayed, and outcomes for individuals served through the system less than optimal.

DMH's Mental Health Information System (MHIS) is an example of both a strength and weakness in the system. MHIS is a comprehensive information management system for behavioral health. It is a version of the Meditech health management system heavily customized for behavioral health and DMH. Massachusetts is recognized as one of the first states to adopt a behavioral health electronic record and DMH is thus able to provide easily accessible client level data including demographic information and service level encounter data. However, a weakness of MHIS is the lack of integration with community providers, resulting in a limited data set for DMH consumers who do not receive state-operated case management services. This is reflected in the fact that many of the performance indicators within this Plan are relevant for clients receiving case management services only. Another limitation is that information for roughly one third of the continuing care inpatient population is not stored in MHIS, because those units are housed in facilities operated by the state Department of Public Health or in a contracted community-based inpatient facility, both of which use a separate electronic health record.

Massachusetts

Adult - Unmet Service Needs

Adult - An analysis of the unmet service needs and critical gaps within the current system, and identification of the source of data which was used to identify them.

Unmet Service Needs - Adult

Access to and availability of services continues to be a high priority for DMH. DMH makes every effort to provide at least one community-based service to all adult clients. However, the need for case management and residential support services remains greater than the current capacity. DMH's Mental Health Information System (MHIS) maintains data on DMH clients who are currently receiving case management and residential support services and those who are on waitlists for these services.

DMH also recognizes the ongoing need to reduce racial and ethnic disparities in the accessibility, availability and quality of mental health services. In the last several years, DMH has made significant efforts to ensure that demographic information in MHIS is accurate concerning age, gender, race, ethnicity and preferred language. DMH is currently analyzing data on race and ethnicity as a part of the annual consumer satisfaction survey and the DMH eligibility/ineligibility and service enrollment study. Multicultural and disparities research has also become a required area of research for DMH's two Centers of Excellence. DMH is particularly interested in the sustainability of culturally and linguistically competent services and in demonstrating the outcomes of such services for culturally and linguistically diverse populations.

In addition, DMH has identified several underserved populations, including elders and individuals who are homeless. Within this Plan, DMH presents prevalence data for adults age 65 and over. DMH has also collaborated with the Massachusetts Behavioral Health Partnership (MBHP) to review data on access to emergency screening and with the Executive Office of Elder Affairs (EOEA) to analyze data pertaining to elders who undergo mandatory mental health screening for nursing home admission. Regarding homelessness, DMH has instituted a Housing Assessment for DMH clients receiving case management to identify clients who are homeless and at risk from homelessness. DMH also utilizes data from the Massachusetts Housing and Shelter Alliance (MHSA), a study on homelessness in Massachusetts conducted by the Human Services Research Institute (HSRI) in Cambridge, Massachusetts and from the Department of Transitional Assistance (DTA) – the state agency which funds the state's sheltering system. DMH also continues to monitor MHIS data related to access and appropriateness of services offered to other underserved populations including: clients with co-occurring disorders, transition age youth and deaf and hard of hearing clients.

Both the Adult and Child/Adolescent Restraint Reduction/Prevention Initiatives have identified several unmet needs in promoting a strength-based and recovery oriented system of care. Despite the significant progress made within inpatient facilities, there is a need to bridge this effort with other levels of care. A second need relates to the full inclusion of consumers in meaningful roles throughout the system of care. This refers not only to hiring persons who disclose a history of receiving mental health services, but also to current and former consumers now living in the community who could serve on boards, committees and decision making groups.

The National Association of State Mental Health Program Directors (NASMHPD) Medical Directors Council's recent report, documenting the fact that people with serious mental illness die about 25 years earlier than the general population, has created a renewed sense of urgency in addressing physical health disparities. In 1999, DMH was one of the first states to document the excess mortality among persons

with serious mental illness compared to the Massachusetts general population. In 2007, under the leadership of the State Medical Director, additional analysis was undertaken, comparing death rates between the populations from the years 2000 through 2004. This analysis addresses specific diseases that account for these deaths, in addition to further documenting this significant disparity in health outcomes.

Massachusetts

Adult - Plans to Address Unmet Needs

Adult - A statement of the State's priorities and plans to address unmet needs.

Plan to Address Unmet Needs - Adult

In regards to improving access to specific services and underserved populations, DMH is in the process of developing a monthly management report of community indicators to assist DMH managers in identifying and prioritizing needs. The report will include indicators related to case management and residential support services, the DMH eligibility application process and access to community-based services. This increased focus on system-wide reporting will allow DMH to monitor current levels of access and identify areas for targeted expansion.

The FY 2008-2010 Cultural Competence Action Plan (CCAP), currently under development, intends to address racial and ethnic disparities through the development of specific strategies and the monitoring of measurable outcomes. The CCAP is expected to address:

- Access across racially and ethnically diverse populations at the system level;
- Availability of appropriate cultural and linguistic services at the service delivery level;
- Access to language, information and referral services that is population and geography-based;
- Development and implementation of uniform cultural and linguistic service standards; and
- Measurement of outcomes of children, adolescents, adults and families served.

DMH is engaged in ongoing, collaborative efforts to address the unmet needs of elders, transition age youth, deaf and hard of hearing clients, clients with co-occurring disorders and clients who are homeless. These initiatives are described in detail in other sections of the plan, including Planning Council, State Agency Leadership, and Criterion I, II, and IV.

The Adult and Child/Adolescent Restraint Reduction/Prevention Initiatives continue to work on the spread of best practices into other systems of care and with other efforts to expand the meaningful role of consumers in this process.

As discussed in "Unmet Needs," DMH is examining physical health disparities through a study of Massachusetts death rates led by the State Medical Director. Additional analysis will identify the specific diseases that account for these deaths and the report will recommend preventive measures on the state, agency, provider and consumer levels for early identification, assessment and multimodal interventions. DMH is also addressing this issue through its commitment to train the next generation of psychiatrists and psychologists to practice effectively in the public sector. In order to meet this goal, DMH has worked closely with the Commonwealth's medical schools to develop a curriculum that emphasizes health and wellness and the integration of medical care and psychiatric care. Training requirements in these key competencies were first included in the DMH's FY 2004 Psychiatry Residency and Psychology Internship Training Program. DMH expects to re-procure the Training Program contracts during FY 2009 for a July 1, 2009 contract start date. The Request for Responses (RFR), when issued, will again ask the medical schools to demonstrate how health and wellness and the integration of medical care and psychiatric care have been incorporated in the didactic training and clinical experiences of its residents, interns and fellows. In addition, DMH

has engaged in a project, the Healthy Changes Initiative, to address the modifiable risk factors for premature death and disability. This project is presented in the Description of Transformation Activities section of the plan.

Massachusetts

Adult - Recent Significant Achievements

Adult - A brief summary of recent significant achievements that reflect progress towards the development of a comprehensive community-based mental health system of care.

Recent Significant Achievements - Adult

The recent achievements reflecting progress towards the development of a comprehensive community-based mental health system of care are listed below. Each achievement is described further in the identified section of the Plan.

- Construction of a new DMH state-of-the-art psychiatric facility beginning in the Spring of 2008 on the grounds of Worcester State Hospital with completion scheduled for 2011 or 2012. The new hospital will serve all of central Massachusetts and is designed for 260 adult beds, 30 adolescent inpatient beds, and 30 IRTP beds. (Executive Summary and Overview of State's Mental Health System)
- Decrease in inpatient census and the addition of 268 community placements (Executive Summary and Overview of State's Mental Health System)
- Establishment of a Quality Council by Commissioner Leadholm and the development of a Quality Framework (Executive Summary)
- Consolidation of the consumer affairs office with the agency's communications office to create the Office of Communications and Consumer Affairs (Executive Summary)
- Development of Recovery Learning Communities, a consumer-operated service and support network (Executive Summary and Description of Transformation Activities)
- Recent issuance of a Request for Information (RFI) seeking public recommendations as to how best to redesign the DMH community-based service system (Executive Summary)
- Development of a statewide monthly Inpatient Indicator Report (Description of Transformation Activities)
- Training of all direct care staff in state-operated inpatient facilities in modules reflecting the values of the Restraint and Seclusion Reduction Initiative (State Agency Leadership and Description of Transformation Activities)
- Significant statewide reduction in the use of seclusion and restraint and resultant culture change toward a more inclusive, recovery-oriented and strengths-based environment of care (State Agency Leadership and Description of Transformation Activities)
- Development of a groundbreaking model of coordinated behavioral health, public health and primary care services through the Community Health Center/Community Mental Health Center (CHC/CMHC) pilot project (Description of Transformation Activities)
- Expansion of services for transition age youth, ages 16-25, with a legislative allocation of $3M in new dollars for FY 2008, bringing to $9M the amount of funding specifically dedicated to this population (Criterion I)
- Continuing funding and development of the Transformation Center, a statewide technical assistance center for the consumer/survivor movement (Description of Transformation Activities)

- Development of a Certified Peer Specialist training program, resulting in the certification of approximately 95 Certified Peer Specialists (Description of Transformation Activities)
- Completion of the 3-year Cultural Competence Action Plan which established major building blocks for culturally and linguistically competent care (State Agency Leadership)
- Establishment of an annual Consumer and Family Member Satisfaction Survey, utilizing a sound methodology of stratified random sampling and multiple survey methods (Goals, Targets, Plans)
- Changes to the DMH eligibility application process to improve efficiency and create a more user-friendly process (Criterion II)
- Re-contracting of the two DMH Centers of Excellence with several enhancements addressing improved communication, consumer and family involvement , a "Science to Service to Science" perspective, and a focus on multicultural and child, adolescent and family research (State Agency Leadership)
- Development of the Healthy Changes Initiative, designed to address the modifiable risk factors brought on by treatable medial conditions (Description of Transformation Activities)

Massachusetts

Adult - State's Vision for the Future

Adult - A brief description of the comprehensive community-based public mental health system that the State envisions for the future.

State's Vision for the Future

With a new commissioner and leadership, DMH has renewed its focus on consumer and family voice in all areas of DMH's work and a mission that embodies recovery and resiliency.

Barbara A. Leadholm, M.S., M.B.A., was named DMH commissioner in September 2007 and has clearly articulated her vision for DMH in the overarching message of *Recovery and Resiliency Through Partnership*. Through Commissioner Leadholm's leadership, DMH is grounded in its commitment to provide consumers of all ages with improved access to services and to facilitate DMH's role in assuring such access. This vision is built upon three priorities:

Recovery and resiliency. These are the core principles that DMH embraces and its goal is to strengthen and increase awareness of respect for consumers and families, through strength-based approaches to care and a commitment to recovery and resiliency.

Strengthen the Public Mental Health System. The vision is to develop a service system that embraces the principles of recovery and resiliency through Partnership with consumers and family members, emphasizing rehabilitation, person-centered and client-driven care. In order to align the public mental health system with these values, DMH is considering significant changes in the service delivery philosophies and contracting approaches of its adult system. In addition, DMH is actively participating in the Executive Office of Health and Human Service's Children's Behavioral Health Initiative. Central to these changes, is an emphasis on promoting the achievement of consumer and family outcomes

Continuous Quality Improvement. With the establishment of the Quality Council guided by the development of a Quality Framework, Commissioner Leadholm created an infrastructure to complement and support the DMH mission as well as the goals of housing, education and employment of Governor Patrick and the Executive Office of Health and Human Services. The Quality Framework represents the new paradigm of how DMH will forward its mission of Recovery and Resiliency through renewed focus on consumer, family and system outcomes in the priority areas of community integration, recovery, health and wellness, and access to services and supports.

Consumer and family involvement in all aspects of DMH's work is critical to the mission of Recovery and Resiliency, especially as DMH identifies itself as the standard bearer of a public mental health system that infuses quality, promotes evidence-based practices and the use of data in creating a consumer driven, and for minors a family driven, and person centered system of care.

Massachusetts

Child - Service System's Strengths and Weaknesses

Child - A discussion of the strengths and weaknesses of the service system.

DMH has chosen to integrate the adult and child narrative for this section of the plan for the following reasons. First, the Child and Adolescent Division of DMH resides within Program Operations at Central Office. New applicants who are age 18 and who meet adult eligibility criteria are entered as adults; if they do not meet adult criteria they may become eligible under the child/adolescent criteria. Individuals under the age of 19 may receive adult services when clinically appropriate as adults over the age of 19 may receive child and adolescent services when appropriate. Furthermore, DMH has placed significant emphasis on planning for transition age youth between the ages of 16 and 25. This age grouping encompasses both the child/adolescent and adult systems. Lastly, the Rosie D Class, as described in the Executive Summary, includes children up to age 21. DMH recognizes the need for its child, adolescent and young adult services to align with and complement Rosie D services.

Massachusetts

Child - Unmet Service Needs

Child - An analysis of the unmet service needs and critical gaps within the current system, and identification of the source of data which was used to identify them.

Unmet Service Needs - Child

Access to and availability of services continues to be a high priority for DMH. DMH makes every effort to provide at least one community-based service to all child and adolescent clients and tracks this data as a performance indicator in the State Plan. However, the need for case management and residential support services remains greater than the current capacity. DMH's Mental Health Information System (MHIS) maintains data on DMH clients who are currently receiving case management and residential support services and those who are on waitlists for these services. Children who no longer need inpatient or other acute care, but who remain "stuck" in hospitals or other acute settings for lack of appropriate discharge plans are yet another indicator of the difficulty in accessing services. They also impede access to hospitalization for new admissions as beds are unavailable. MBHP reports weekly on the number of "stuck" kids to DMH, DSS and EOHHS.

DMH recognizes the ongoing need to reduce racial and ethnic disparities in the accessibility, availability and quality of mental health services. In the last several years, DMH has made significant efforts to ensure that demographic information in MHIS is accurate concerning age, gender, race, ethnicity and preferred language. DMH is currently analyzing data on race and ethnicity as a part of the annual consumer and family member satisfaction survey and the DMH eligibility/ineligibility and service enrollment study. Multicultural and disparities research has also become a required area of research for DMH's two Centers of Excellence. DMH is particularly interested in the sustainability of culturally and linguistically competent services and in demonstrating the outcomes of such services for culturally and linguistically diverse populations. DMH also continues to monitor MHIS data related to access and appropriateness of services offered to other underserved populations including: clients with co-occurring disorders, transition age youth and Deaf and Hard of Hearing clients.

A trauma-sensitive approach to treatment is needed throughout the DMH system. The Child/Adolescent Restraint Prevention Initiative has led to significant progress within the programs initially targeted for change, namely the inpatient facilities and intensive residential treatment programs. The work needs to expand to encompass community residential providers.

Children and adolescents with autism spectrum disorders and severe behavior problems continue to present a service challenge. The Department of Mental Retardation (DMR) has been charged with planning for youth up to age 18 along the autism spectrum. However, there remains a need for additional service resources.

Massachusetts

Child - Plans to Address Unmet Needs

Child - A statement of the State's priorities and plans to address unmet needs.

Plan to Address Unmet Needs - Child

In regards to improving access to specific services and underserved populations, DMH is in the process of developing a monthly management report of community indicators to assist DMH managers in identifying and prioritizing needs. The report will include indicators related to case management and residential support services, DMH eligibility application process and access to community-based services. This increased focus on system-wide reporting will allow DMH to monitor current levels of access and identify areas for targeted expansion. DMH will continue to be an active participant in interagency activities developing strategies to fix and monitor the "stuck kid" problem. Finally, DMH will continue to play a key role in state activities that respond to the Rosie D lawsuit and that will culminate in significant expansion of intensive home and community based mental health services for youth up to age 21 who are determined to have SED and who are Mass Health enrollees.

The FY 2008-2010 Cultural Competence Action Plan (CCAP), currently under development, intends to address racial and ethnic disparities through the development of specific strategies and the monitoring of measurable outcomes. The CCAP is expected to address:

- Access across racially and ethnically diverse populations at the system level;
- Availability of appropriate cultural and linguistic services at the service delivery level;
- Access to language, information and referral services that is population and geography-based;
- Development and implementation of uniform cultural and linguistic service standards; and
- Measurement of outcomes of children, adolescents, adults and families served.

DMH is engaged in ongoing, collaborative efforts to address the unmet needs of elders, transition age youth, Deaf and Hard of Hearing clients, clients with co-occurring disorders and clients who are homeless. These initiatives are described in detail in other sections of the plan, including Planning Council, State Agency Leadership, and Criterion I, II, III and IV. Also, EOHHS has recently submitted an application for a Real Choices grant for Person Centered Planning and DMH will be an active participant in activities related to children with autism spectrum disorders and severe behavioral problems should the state's application be approved.

The Child/Adolescent Restraint Prevention Initiative will engage in a collaborative process aimed at eliminating the use of restraints in community residential programs, replicating the successful process it engaged in with inpatient and intensive residential treatment program providers. Community residential programs are often the next level of care for children who have been in more restrictive settings.

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Massachusetts

Child - Recent Significant Achievements

Child - A brief summary of recent significant achievements that reflect progress towards the development of a comprehensive community-based mental health system of care.

Recent Significant Achievements - Child

The recent achievements reflecting progress towards the development of a comprehensive community-based mental health system of care are listed below. Each achievement is described further in the identified section of the plan.

- Release of the Inpatient Study Report for the General Court of March 2004 and the passage of bond authorization in 2007 for the construction of a new state of the art psychiatric facility that will include 30 continuing care adolescent inpatient beds and 30 intensive residential treatment beds.(Executive Summary and Overview of State's Mental Health System)
- Significant statewide reduction in the use of seclusion and restraint and resultant culture change toward a more inclusive, resilience and recovery-oriented and strengths-based environment of care (State Agency Leadership and Criterion I)
- Expansion of services for transition age youth, ages 16-25 (Criterion I)
- Completion of the 3-year Cultural Competence Action Plan which established major building blocks for culturally and linguistically competent care (State Agency Leadership)
- Establishment of an annual Consumer and Family Member Satisfaction Survey, utilizing a sound methodology of stratified random sampling and multiple survey methods (Goals, Targets, Plans)
- Establishment of a statewide quality improvement structure and projects (Executive Summary)
- Changes to the DMH eligibility application process to improve efficiency and create a more user-friendly process (Criterion II)
- Seventy-eight percent of the state's pediatric practices enrolled in the Massachusetts Child Psychiatry Access Project that provides psychiatric consultation to community pediatric practices (Criterion I)

Massachusetts

Child - State's Vision for the Future

Child - A brief description of the comprehensive community-based public mental health system that the State envisions for the future.

DMH has chosen to integrate the adult and child narrative for this section of the plan for the following reasons. First, the Child and Adolescent Division of DMH resides within Program Operations at Central Office. New applicants who are age 18 and who meet adult eligibility criteria are entered as adults; if they do not meet adult criteria they may become eligible under the child/adolescent criteria. Individuals under the age of 19 may receive adult services when clinically appropriate as adults over the age of 19 may receive child and adolescent services when appropriate. Furthermore, DMH has placed significant emphasis on planning for transition age youth between the ages of 16 and 25. This age grouping encompasses both the child/adolescent and adult systems. Lastly, the Rosie D Class, as described in the Executive Summary, includes children up to age 21. DMH recognizes the need for its child, adolescent and young adult services to align with and complement Rosie D services.

Massachusetts

Adult - Establishment of System of Care

Adult - Provides for the establishment and implementation of an organized community-based system of care for individuals with mental illness.

Criterion 1: Comprehensive Community-Based Mental Health Services

Establishment of System of Care

Massachusetts has provided community-based care since 1966, when the legislature created the structure for an area-based system. Until 1991, however, a disproportionate share of DMH's resources was tied up in the state's antiquated psychiatric hospitals. Since that time, five hospitals have been closed (four adult and the only state-operated children's hospital) and savings have been reinvested in community programs and infrastructure, clients and other stakeholders have increased their participation in planning and policy development, and area-based management has been anchored by statewide standards. These changes have created an enhanced and vigorous community-based system of care for adults, children and adolescents.

Massachusetts

Adult - Available Services

Adult - Describes available services and resources in a comprehensive system of care, including services for individuals with both mental illness and substance abuse. The description of the services in the comprehensive system of care to be provided with Federal, State, and other public and private resources to enable such individuals to function outside of inpatient or residential institutions to the maximum extent of their capabilities shall include:

Health, mental health, and rehabilitation services;
Employment services;
Housing
services;
Educational services;
Substance
abuse services;
Medical and dental services;
Support services;
Services provided by local school
systems under the Individuals with Disabilities Education Act;
Case management services;
Services
for persons with co-occurring (substance abuse/mental health) disorders; and
Other activities
leading to reduction of hospitalization.

Criterion 1: Comprehensive Community-Based Mental Health Services

Available Services Narrative

DMH directly provides and/or funds a range of services for approximately 24,000 adult clients per year. These services include extended stay inpatient care, emergency services, case management and other community and rehabilitative services. Publicly funded acute-care services, including inpatient, emergency and outpatient services are managed by MassHealth.

Health and Mental Health Services

While the majority of health and mental health outpatient services for DMH clients are provided through MassHealth, DMH supports the health and wellness of individuals in a number of ways. DMH actively works with the Department of Public Health (DPH) in bringing to DMH clients DPH programs targeting obesity, physical inactivity, smoking and cardiovascular risk reduction. DMH continues to fund a research project to help DMH clients in the community with schizophrenia, schizoaffective disorder and bipolar disorder reduce or stop smoking. DMH case managers connect clients to appropriate health and mental health services and monitor the quality and effectiveness of these services. Residential and other support services provide symptom management, medication monitoring and education and assistance in accessing psychiatric and medical services and benefits.

In addition, DMH conducted a Well-Being and Recovery conference in May 2007 for employees within the community and inpatient system of care. This conference provided training on the health care system, interventions in the treatment of nicotine dependence and diabetes, and strategies to assist clients in making healthy nutrition and exercise choices. DMH is also engaged in a project, the Healthy Changes Initiative, which is designed to address the modifiable risk factors brought on by treatable medial conditions. This initiative is presented in the Description of Transformation Activities section of the plan.

Rehabilitative and Support Services

As DMH is the primary provider/contractor of continuing care community-based services, rehabilitation and support are at the core of its programs. Most community-based programs provide both rehabilitative and supportive functions in a flexible manner to match the goals and needs of the individual client. These include case management, residential services, clubhouses, Program of Assertive Community Treatment (PACT), Community Rehabilitation Support (CRS) and Services for Education and Employment (SEE). For instance, DMH residential services are designed to ensure maximum flexibility to meet the changing needs of residents and provide support, supervision, treatment and rehabilitation to clients living in the community. Each individual receiving a residential service has a Program Specific Treatment Plan (PSTP) specifying the rehabilitative service components that will be provided and the outcomes these services are expected to achieve. Community Rehabilitation Support (CRS) provides general rehabilitation, support and assistance with medication. The emphasis of these interventions is on outreach and engagement for clients who may not utilize more

traditional community-based services. In addition, DMH offers services focused on recovery and client empowerment. In a shift towards consumer-directed care, DMH funds and supports a variety of consumer initiatives, including peer and family support, peer mentoring, warm-lines and recovery learning communities.

As described in the Executive Summary, DMH has recently issued a Request for Information (RFI) seeking public recommendations as to how best to redesign its community-based services.

Employment Services

DMH sponsors community-based programs to assist clients with achieving employment or educational objectives; both as a means of furthering a client's recovery process and his or her economic well-being. DMH delivers these services to clients primarily by contracting with private vendors. The major programs of this type are the Services for Education and Employment (SEE) and Community Support Clubhouses.

- Services for Education and Employment (SEE)
  The SEE program consists of 25 local projects in communities across the state. The program strives to assist DMH clients in securing employment; obtain work training; and/or address remedial, basic, or post secondary education needs. Clients are offered flexible, individualized supports with the goal of producing permanent employment with mainstream employers. Education and/or training placements are also offered, with the intent of better preparing clients to enter into competitive employment. The individual SEE projects engage in active job development in their communities and form relationships with employers and mainstream employment, training, and educational systems external to the mental health community.
- Community Support Clubhouses
  DMH's Community Support Clubhouses provide members with a range of career counseling, job search, training, support, and placement services for obtaining and maintaining permanent, supported, and transitional employment. Clubhouses also serve as multi-service centers for DMH clients and other persons with mental illness living in the community. In addition to the more traditional job development, training, and employment services offered, each clubhouse operates under a "work ordered day" philosophy. Clubhouses pursue a variety of jobs for members including integrated, independent employment.

Clients also receive employment services through DMH's Program of Assertive Community Treatment (PACT), which are not employment programs per se but each PACT team does offer employment services within its mix of community-based client services.

In addition DMH participates in several initiatives and interagency activities to promote the employment of DMH clients. These include:

- *The EOHHS Employment Steering committee*. This interagency committee was convened to guide EOHHS and member agencies on their employment efforts. It is focused on both policy and operations and is concerned with streamlining agency projects towards a range of expressed improvements.

- *The EOHHS MassGOALS committee*. Through EOHHS, DMH participated in an executive work group that identified a range of economic growth and workforce development objectives for the new Patrick-Murray Administration. These goals included strengthening EOHHS agency employment programs benefiting persons with disabilities including those with mental illness.
- *SEE-Technical Assistance Project (SEE-TAP)*. Under the Medicaid Infrastructure Comprehensive Employment Opportunities (MICEO) Grant from the Centers for Medicaid to Massachusetts, DMH is receiving research and technical assistance services for its Services for Education and Employment program (SEE). In SFY08, The Center for Health Policy Research at the UMass Medical School conducted research on the predictive factors of employment in DMH SEE programs, including analysis of client-level program data and fidelity assessments of each DMH-funded program, and held a training on the Individual Placement and Support model of employment.

Housing Services

DMH has sponsored aggressive efforts to increase supported housing opportunities for its clients. DMH Central Office maintains a housing staff which works with DMH providers and state and local housing agencies to promote housing supply development efforts in support of DMH's locally administered discharge planning process and to achieve other DMH agency-wide housing and community-based treatment goals. This Central Office housing function is carried out in conjunction with Area Housing Coordinators in each of DMH's six Area Offices. DMH's work has resulted in creating a housing capacity for 6040 individuals in its community services system. Of this capacity, 77% of the housing units receive federal or state subsidies leveraged by DMH. These living arrangements provide a range of options from congregate living to independent apartments integrated fully within the community.

In May 2008 Governor Patrick signed the Housing Bond Bill into law. This law reauthorized the Facilities Consolidation Fund (FCF) which provides financing assistance to developers creating housing for clients of the Department of Mental Health and the Department of Mental Retardation. In addition to providing $25 million in funding for the program, the law contains a provision for which DMH had long been advocating. This provision allows FCF funding to be given as to "for-profit" housing development organizations in addition to the long eligible non-profit organization. DMH expects to obtain a greater volume of new, scattered-site apartments because of this provision.

Substance Abuse Services/Services for Persons with Co-Occurring Disorders

DMH is committed to including those with a dual diagnosis of serious mental illness and substance abuse in its programs and services and in providing them with integrated treatment. DMH incorporated program standards for the care and treatment of individuals with co-occurring disorders into its Residential Services contracts. All residential providers are now required to meet these standards. In addition, training requirements for managing individuals with co-occurring disorders were included in the Department's FY 2004 Psychiatry Residency and Psychology Internship Training Program. DMH expects to re-procure the Training Program contracts during FY 2009 for a July 1, 2009 contract start date. Training requirements for managing individuals with

co-occurring disorders, with an emphasis on integrating the physical and mental health aspects of co-occurring treatment, will again be included in the Request for Responses (RFR) when issued. Lastly, the Massachusetts Behavioral Health Partnership (MBHP) completed two performance incentive projects related to co-occurring disorders in FY 2007. These projects related to enhancing the network capacity for the treatment of adolescents and transition age youth with co-occurring disorders and developing guidelines for the use of Buprenorphine treatment. These performance incentive projects continued in FY 2008 with a focus on continued enhancement of network capacity and the distribution of Buprenorphine treatment guidelines.

Medical and Dental Services

There are several ways in which DMH addresses access to primary health care. One of the requirements included in the annual review of each client's Individual Service Plan, as per the Service Planning regulations, is evidence of an annual physical and dental exam. DMH also tracks whether adult clients in residential programs see their primary care physician annually. DMH is actively committed to improving access to primary care and increasing the likelihood that individuals access available care. DMH and MassHealth support case managers' direct contact with DMH clients' primary care clinicians to ascertain whether clients are linked with this important resource. Additionally, it was reported in the previous State Plan that dental benefits had been eliminated for MassHealth recipients. This benefit has been restored, returning access to dental care to the majority of DMH clients who receive MassHealth benefits.

Services Provided by Local School Systems under the Individuals with Disabilities Education Act (IDEA)

Local school systems are required under state and federal law to provide a range of services to children and adolescents (up to age 22 or receipt of a high school diploma, whichever comes first) who are disabled by reason of emotional disturbance to the extent that they require special education and related services. These services include in-class supports, counseling and, for children with more severe needs, educational services outside of a regular classroom and in special education day and residential schools. DMH provides training to case managers on transition requirements under the Individuals with Disabilities Education Act (IDEA). DMH parent support coordinators and the Parent Professional Advocacy League (PAL) are available to assist parents with individual special education advocacy issues regardless of the child's age. Youth up to age 22 who are hospitalized in DMH facilities have access to special education services. DMH has actively participated in a work group led by Massachusetts Advocates for Children that has developed written materials and changed Department of Education (DOE) forms with the goal of improving access to services for transition age youth.

Case Management Services

Since it developed its case management policy in 1987, DMH has acknowledged the importance of case management and individual service planning in connecting clients to needed services, but has not had sufficient resources to assign a case manager to each eligible client. Therefore, the policy established priority for state-operated case management services for those adults with serious, long-term mental illness and children

with serious emotional disturbance who were being discharged from inpatient stays or with a history of repeated psychiatric hospitalizations, homeless with mental illness, or unable to meet life support needs of shelter, food, clothing and self-care. They also were mandated specifically for children deemed eligible for DMH continuing care community services. Case management was organized primarily as a "brokerage" model.

In SFY'98 and SFY'99, DMH undertook a thorough examination of the DMH case management system. This project began as DMH was revising the remaining section of its regulations on service planning (SP) and occurred at the same time that a uniform process to determine eligibility for DMH continuing care community services was being implemented. The SP project involved a task force, focus groups and extensive public input from all of DMH's stakeholders and succeeded in defining a "DMH client" in a behavioral managed mental health care environment. After significant public comment and further review, the final regulations were promulgated on July 1, 1999 with a phased-in implementation process planned. The regulations state that every individual who meets the clinical criteria, is determined to be in need of at least one existing DMH continuing care community service, and has no other means of obtaining that service will be eligible for DMH community services, including case management. Case management remains a state-operated service. Clients are assigned a case manager based on the intensity of their need and as resources permit. Subject to available resources, every DMH client is eligible for DMH case management. The only exceptions to this rule are adult clients assigned to Program for Assertive Community Treatment (PACT) teams who receive intensive case management as part of the program design. While it is clear that DMH does not have the resources presently to provide a case manager for every eligible client, a process has been developed to triage clients to determine their priority of need. Clients waiting for case management or residential services are often assigned to other community services.

Reducing the Rate of Hospitalization

DMH has continued to work hard to shift its focus to community-based care. Since 1992, DMH has closed five state hospitals, including the state-operated children's center, and phased out the contracted latency age unit, transferring responsibility for acute care from the public to the private sector. In addition to reducing the number of beds in the DMH system, this also has enabled DMH to focus its expertise on providing continuing and rehabilitative care in the community. The expansion of diversionary services and other community supports, and the entrance of behavioral managed care have substantially reduced the rate of hospitalization.

As of June, 2008, DMH has 850 inpatient beds. These are spread among three DMH-operated state psychiatric hospitals, four community mental health centers (CMHCs), two contracted adolescent units housed in a state psychiatric hospital, mental health units in two public health hospitals, and one contracted adult unit in a private hospital. The total capacity, which includes beds for forensic patients, includes 820 adult beds and 30 adolescent beds. All are extended stay beds with the exception of three 16-bed CMHC acute units. Children, adolescents and most adults receive acute inpatient care in private or general hospitals, with the exception of adult admissions to the CMHC acute units and some forensic admissions.

In 2006, DMH became concerned with the rate at which DMH clients were being readmitted to acute-care facilities. The Massachusetts Behavioral Health Partnership (MBHP) tracks 30-day readmission rates as a part of the management of its provider network. A quality improvement project was formed in November 2006 with the aim of reducing 30-day readmission rates for DMH/MBHP clients to acute-care inpatient facilities. A joint partnership between DMH, the MassHealth Behavioral Health Unit and MBHP, this statewide Readmission Collaborative has approximately 50 members representing these three organizations, consumers and providers. The Collaborative utilizes data, shared learning and rapid Plan-Do-Study-Act cycles to implement, test and spread interventions intended to reduce readmission rates. The Collaborative will conclude in July 2008 with the development of a set of recommended interventions to be implemented statewide.

In 2008, a performance improvement workgroup was formed with membership from DMH, the MassHealth Behavioral Health Unit, MBHP and the Massachusetts Association of Behavioral Health Systems (MABHS), a trade group representing acute-care behavioral health units and hospitals. This workgroup was initially formed with the goal of reducing the amount of time individuals referred from acute-care facilities to DMH inpatient continuing care facilities wait for placement. However, the scope of the workgroup has expanded to include interventions to increase community diversions and reduce acute-care readmissions due to the relatedness of these issues and the value of promoting community tenure.

Services for Clients with Special Needs

Deaf, Hard of Hearing and Late-deafened

DMH continues to maintain and increase its services to Deaf and Hard of Hearing clients. There are currently four Deaf or ASL fluent case managers who provide case management services across the state. Approximately 100% of DMH Deaf clients are served by a signing case manager or the signing case manager works with the non-signing case manager. Approximately 90% of clients have reliable accessibility in their treatment programs. DMH has also established procedures that require that access issues be addressed in Individual Service Plans and during the process of eligibility. Funds directed towards expanded residential, community support and vocational services have been maintained. These services are coordinated through a part-time position at Central Office. For the next FY one goal is to develop and implement a way to assess the ASL fluency of non-deaf staff that work with Deaf DMH clients who use ASL. As described in Transformation Activities, DMH contracted with the Transformation Center, a consumer-led technical assistance center, to explore ways to adapt and use Wellness Recovery Action Plans (WRAP), developed by Mary Ellen Copeland in the Deaf and Hard of Hearing community.

Parents with Mental Illness

The Department of Children and Families and DMH have developed regionally based collaborative training programs and protocols to facilitate service plans that will provide parents with needed services and support. The adult DMH eligibility form asks about parenting status on the face sheet, a recognition that all adults with mental illness,

regardless of Department of Children and Families involvement, may need support in their parenting role. DMH plans to specifically address parenting support in its future service procurements. A new contracting requirement for adult Clubhouses now requires them to report on the number of their members who are parents which has raised awareness of the need to address this domain. Three inter-related parenting projects sponsored by Employment Options (a clubhouse) may provide evidence-based guidance. The Family Options project provides care management for the entire family unit, both parent and child, and offers a resource center for families involved in the program. The project, a partnership of UMass Medical School Research Team and Employment Options, had grant-based funding that also supported research on its process and outcomes. An evidence-based documentary and discussion guide was developed and a practice manual is in process. The Clubhouse Family Project offers services such as visitation support, parenting education, home visits, service coordination, liaison with the Department of Children and Families, parent support groups, and advocacy that help parent gain the hands-on learning experience they need to acquire and use their parenting skills. Finally, the Clubhouse Family Legal Support Project, now funded by DMH, the Boston Bar Foundation, and the Mass Bar Foundation, provides legal support to parents who are mentally ill to assist them in gaining visitation orders, increasing visitation time with their children, as well as maintaining and regaining custody of their children. DMH and UMass staff, as well as advocates from PAL, the Mental Health Legal Advisors Committee, and local service providers are active participants on an advisory committee exploring ways of broadening accessibility to the expertise developed by these projects and promoting statewide replication.

Massachusetts

Adult - Estimate of Prevalence

Adult - An estimate of the incidence and prevalence in the State of serious mental illness among adults and serious emotional disturbance among children

Criterion 2: Mental Health System Data Epidemiology

Estimate of Prevalence

*Prevalence Estimates for Adults (based on 2006 census-derived population estimates)**

DMH Area	Adults (19-64) with Serious Mental Illness (5.7%)	Adults (19-64) with Serious and Persistent Mental Illness (2.6%)	Adults (19-64) with Serious & Persistent Mental Illness and Severe Dysfunction** (.98%)	Elders (65+) with Mild Mental Health Problems (16.33%)	Elders (65+) with Moderate Mental Health Problems & some Functional Impairment (2.1%)	Elders (65+) with Serious Mental Illness w/ Associated Disability or Severe Functional Impairment** (1.57%)
Western Mass	28,697	13,090	**4,934**	**18,869**	**2,426**	**1,814**
Central Mass	29,322	13,375	**5,041**	**19,280**	**2,479**	**1,854**
North East	44,068	20,101	**7,577**	**28,975**	**3,726**	**2,786**
Metro Boston	31,946	14,572	**5,492**	**21,005**	**2,701**	**2,019**
Metro Suburban	45,629	20,813	**7,845**	**30,002**	**3,858**	**2,884**
Southeastern Mass	44,160	20,143	**7,592**	**29,036**	**3,734**	**2,792**
Total	**223,822**	**102,094**	**38,481**	**147,167**	**18,924**	**14,149**

* Prevalence estimates are based on federal methodology and DMH planning data.

** Severely disabled adults, unable to provide for basic self-care. DMH estimates approximately half will seek or use public mental health services at any given time (the target population). Despite waiting lists for high demand or high intensity services such as case management, PACT and residential services, most adults who apply and meet the DMH eligibility criteria receive at least one less intensive community service while waiting. Alternatively, they are admitted, if they meet the clinical criteria, to DMH continuing care inpatient services.

Massachusetts

Adult - Quantitative Targets

Adult - Quantitative targets to be achieved in the implementation of the system of care described under Criterion 1

Criterion 2: Mental Health System Data Epidemiology

Quantitative Targets

Please refer to access indicators in the Goals, Targets and Action Plans section.

Massachusetts

Adult - Outreach to Homeless

Adult - Describe State's outreach to and services for individuals who are homeless

Criterion 4: Targeted services to rural, homeless and older adult populations

Outreach to Homeless

DMH demonstrates its commitment to confronting homelessness through significant efforts in increasing and improving housing options and services for homeless individuals as well as through interagency collaboration. This collaboration includes a number of task groups dealing with both policy and service delivery issues. Activities related to housing and homelessness are coordinated by Central Office through the Homeless Initiative (HI).

The Homeless Initiative (HI) primarily provides clinical and residential services to support clients in community-based housing and leverages over $150 million in federal and other housing resources to fund both the development of and client access to housing units. Most of this funding is obtained through the U.S. Department of Housing and Urban Development (HUD) McKinney funds.

Since FY 1992, the DMH Homeless Initiative has enabled DMH to create a capacity for serving and placing an average of 2,400 homeless individuals with mental illness each year. DMH also has developed or gained access to more than 1,200 new units of housing during that time. The program, which is operated statewide with a concentration in the Boston area, is presently funded at $25.7 million per year through state appropriations. In FY 2007, DMH received its first appropriation of new, additional Homeless Initiative funds in four years, totaling $3.2 million. This increase in funding allowed DMH to leverage 150 new units of housing. DMH was able to launch supported housing projects throughout the state and access housing resources from private non-profit housing developers, municipalities, and through several state and federal housing programs such as HUD's McKinney Homeless programs.

DMH's primary statewide outreach and services effort is supported by a $1.4 million per year federal Projects for Assistance in Transition from Homelessness (PATH) grant from the Center for Mental Health Services and $600,000 in state funds. Under the program, clinical social workers regularly visit mainly adult homeless shelters, across the state to connect with persons with mental illness and provide them with such assistance as direct care, housing search and advocacy and referrals to key services. The referrals are to such programs as job training, literacy education, mental health services, substance abuse treatment, and benefits and entitlements. Adults and older adolescents determined to have a serious and persistent mental illness are referred to DMH for eligibility determination. In federal FY 2006, PATH clinicians reached and screened 7,578 individuals throughout the states, with 4,555 becoming PATH clients and receiving on-site assistance and referrals to a range of services. Partners include the Mass Housing and Shelter Alliance, numerous homeless shelters and local Continuums of Care.

In addition, DMH contributes funding for outreach to homeless individuals with mental illness in transitional housing, on the streets and in less populated areas of the state. Members of outreach teams do active street work, ride in medical vans and visit emergency shelters. Physicians from affiliated agencies are available to provide medical care to homeless individuals who will not come into a center or shelter for treatment. The Aggressive Street Outreach program serves individuals and families living in shelters or on the streets in Boston, Waltham, Lowell, Lawrence and Quincy. The program includes successful referrals to housing, detoxification and mental health services.

DMH also manages transitional residences for homeless individuals with mental illness in the Metro Boston Area. These programs receive referrals from non-DMH shelters and are oriented towards stabilization and placement. Each program is affiliated with a DMH community mental health center (CMHC) and has clinically trained staff. The Mobile Homeless Outreach Team in the Metro Boston Area identifies adolescents and adults in need of services and connects them to entitlement programs, case management and other services. The Team also provides psychiatric nurses to non-DMH Boston shelters to treat health problems and manage medication adherence.

DMH and the Department of Public Health (DPH) have been collaborating on a statewide program, the Aggressive Treatment and Relapse Prevention program (ATARP). This program is funded at $1.98 million over three years by a HUD McKinney grant, with an additional $525,000 from DMH and $495,000 from DPH over three years. ATARP has been providing housing and services for homeless clients who have a co-occurring mental illness and substance abuse disorder. Family members of clients can receive housing and services as well. ATARP houses and serves approximately 65 individuals and seven to nine families each year.

In regards to children and families, DMH completed agreements across the state between Family Substance Abuse Treatment Shelters, DMH and the Department of Public Health. These agreements were created to strengthen understanding of the mental health needs of youth in shelters and to provide information about community resources offered by DMH that may be appropriate for families in shelters. As a result of this collaboration, staff has information on access to care, psychopharmacological interventions, signs and symptoms of high-risk behaviors and appropriate use of Emergency Service Programs.

DMH is a member of the Massachusetts Commission to End Homelessness sponsored by the Administration and Legislature, which in FY 2008 issued its report and the Massachusetts 5-Year Plan to End Homelessness. DMH is also an active member of the Massachusetts Interagency Council on Homelessness and Housing, chaired by Lt. Governor Tim Murray. DMH participates in monthly meetings and assists with various aspects of the Council's operations, including participation on several Council work groups. These groups are charged with implementing the state plan.

Additionally, because chronically homeless persons constitute a critical sub-category of the Commonwealth's homeless population, DMH, the Department of Transitional Assistance (DTA) and the Department of Public Health (DPH) have convened a Joint Collaborative to Address Needs of Persons Who Are Chronically Homeless. The group met monthly in 2008 and deals with individuals as well as families. The agencies are coalescing around housing and service issues affecting each other's homeless operations. This group coordinates its work with the Interagency Council on Housing and Homelessness.

Massachusetts

Adult - Rural Area Services

Adult - Describes how community-based services will be provided to individuals in rural areas

Criterion 4: Targeted services to rural, homeless and older adult populations

Rural Area Services

DMH does not have a separate division or special policies for adults, children or adolescents who reside in less populated areas of the state. Each of DMH's 29 Sites has at least one town or incorporated city with a population greater than 15,000 that is considered the center of economic activity for the area. None of the Sites has a population density below 100 people per square mile.

The primary goal of DMH's local planning process is to address the issue of access to services for all DMH clients. Each Site plan identifies target population, needs, available services and resources, gaps in services and resources, and barriers to implementation of a local service delivery system. Geographic distribution of the population is not an issue. Poverty of clients and lack of insurance are more significant variables since the lack of financial resources to pay for transportation interferes with the client's physical ability to get to where services are located and the lack of insurance limits availability. A particular focus relevant to rural populations continues to be access to transportation. At the Area level, many clients have identified this as a challenge. In child and adolescent service contracts, for example, transportation is one of the flexible supports often provided.

Massachusetts

Adult - Older Adults

Adult - Describes how community-based services are provided to older adults

Criterion 4: Targeted services to rural, homeless and older adult populations

Older Adults

A range of specialty residential programs and one Community Rehabilitation Support program have been established to meet the specific needs of the elder population. The remaining DMH services are flexibly designed to meet the needs of DMH clients throughout the lifespan. These community-based services are described in Criterion I. In addition, DMH has been participating with other state agencies in the EOHHS Community First Demonstration project. This project is designed to prevent or delay nursing home admission and to facilitate nursing home discharges to the community. It is also important to note that DMH considers individuals residing in an institutional setting who do not have a permanent residence as homeless. While this definition of homelessness is more expansive than other states, it allows DMH to include the needs of elders and others in institutional settings as a part of homelessness planning. Finally, as a part of DMH's planning process to develop a more integrated service delivery system, older adults have been specifically as one of three major age groupings to receive targeted service resources.

DMH has continued its funding of four forums per year run by the Massachusetts Association of Older Americans. Each forum focuses on the range of issues relating to this population such as integrating medical and psychiatric care for elders with serious mental illness and promoting evidence-based practices.

Over the last four years, DMH and the Executive Office of Elder Affairs (EOEA), the Massachusetts' State Unit on Aging, have taken on a number of initiatives to improve services to older adults. DMH and EOEA have also worked together to leverage the resources of other state agencies, such as the Department of Pubic Health (DPH). These initiatives include: an interagency oversight committee within EOEA to provide advice and guidance on a range of mental health services funded by their agency; new efforts to revisit and invigorate an interagency agreement between DMH and EOEA; and a range of state agency and provider grant opportunities focused on improving care for older adults.

DMH has also been active in the development and design of the Community First 1115 Research and Demonstration waiver which has been submitted to CMS for approval. This waiver is focused on diverting and discharging individuals at a nursing facility level of care. It will expand Medicaid financial and clinical eligibility criteria, while providing access to a broad range of community-based services. There is a particular focus on access to new mental health services for this significantly older and Medicare/Medicaid-eligible population. Medicaid is also reprocuring its managed care network with a focus on improving primary care and behavioral health services for members under 65.

In addition, the Medicaid carve-out vendor, the Massachusetts Behavioral Health Partnership (MBHP), is in the process of redesigning and reprocuring the Emergency Services Program (ESP) provider network, which now includes 26 providers. With the support of DMH, which is also a primary funder, there has been a significant effort to engage other state agencies and local providers through focus groups. Their input has had a significant impact on designing services for elders and other special populations. There have also been efforts by MBHP to train clinicians in the ESP system and aging network

concerning the unique issues of assessing older adults and directing them to appropriate services.

Finally, as discussed in the Planning Council Charge, Role and Activities and the Description of Transformation Activities sections, the Elder Coalition, a sub-committee of the Statewide Planning Council, focuses on the needs and concerns about serving elders. This sub-committee, made up of senior leaders from DMH, EOEA, and DPH, representatives from local provider coalitions, and statewide aging and mental health trade associations, has a history of success in completing projects directed at systems improvement.

Massachusetts

Adult - Resources for Providers

Adult - Describes financial resources, staffing and training for mental health services providers necessary for the plan;

Criterion 5: Management Systems

Resources for Providers

Financial Resources

The estimated SFY'08 state appropriation is $667.4 million, with 73 percent committed to community-based care. This is a zero net percentage change over SFY'07. The SFY'08 direct services budget is $627.3 million, of which $73.5 million is specifically earmarked for child and adolescent services. Of the total state appropriation, $171.5 million is targeted for child, adolescent and adult inpatient services in state hospitals (includes three contracted adolescent units), state-operated community mental health centers and one adult contracted extended stay hospital unit.

DMH clients receive services from state-operated and/or vendor-run programs. The majority of the state-operated programs provide continuing inpatient care in state facilities, although inpatient care accounts for only 27 percent of the DMH budget. Most community services are provided through program contracts with providers. As of August 24, 2007, DMH estimates that there will be contracts in place for SFY'08 for 370 adult programs ($312 million), 182 child and adolescent programs ($79.1 million) and 27 mixed (generic adult/child) programs ($11 million).

Revenue generation is a significant factor in supporting DMH's budget. Since 1988, DMH has significantly increased the amount of revenue it generates from its state hospitals, CMHCs and intensive residential treatment programs, as well as from Medicaid Rehab Option and case management services for DMH Medicaid-eligible clients. Estimated cash revenue in SFY'08 is $115.5 million, compared with *$8.7* million in SFY'88. With the exception of revenue from the CMHCs, which is retained by DMH in statutorily created trust funds under DMH's control, and a small retained revenue account for occupancy fees, all other revenue goes to the General Fund (state treasury). However, since DMH's final state appropriation is evaluated by the legislature on a net state cost basis, revenue generation is a significant factor in supporting DMH's budget.

Human Resources

At the end of FY 2008, DMH directly employed 3845.81 FTE's, compared to 3,776 FTE's at the end of FY 2006. This includes 354.74 case manager (adult and child/adolescent) and eligibility determination specialist positions. DMH continues to analyze staff-to-patient ratios in DMH inpatient facilities as part of DMH's ongoing goal of providing the most up-to-date and data-driven models of services for client recovery in an inpatient setting and providing services and support for reintegration into the community. With a revised classification system for inpatient populations, this analysis allows DMH to better review staffing patterns and manpower needs across its facilities, and also is used to support budget and internal resource requests as necessary.

DMH is actively involved in efforts to increase diversity in the workforce, create a workplace that values and respects the individual diversity of staff, and ensure cultural competency in its programs and services. Each Area's Diversity Committee has developed and is implementing a plan to recruit and train staff, establish local DMH Cultural Competence initiatives that support and celebrate diversity, and find creative ways to support affirmative marketing programs.

Training for Mental Health Providers

In-service training for staff continues to take place at the local level, including mandatory and professional development topics. In FY 2007, CPR training was standardized by requiring all DMH CPR trainers to be certified in the American Safety and Health Institute (ASHI) curriculum and guidelines. Following this change, CPR compliance for DMH staff has increased significantly. Another top priority for DMH continues to be the Restraint Reduction Initiative (RRI) training. All adult inpatient staff is in the process of completing training and compliance rates are excellent. The Child/Adolescent Restraint Prevention Initiative intervention template includes conferences, grand rounds, clinical consultation and technical assistance on state-of-the-art practices for providers of inpatient and intensive residential treatment. These interventions have been expanded to include adult acute and continuing care units/facilities. DMH also maintains its commitment to increase diversity in the workforce and create a workplace that values and respects the individual diversity of staff. In FY 2007, DMH rolled out a Diversity Training that entailed creating curriculum, training 26 Diversity Instructors and scheduling four-hour training sessions for all staff.

The DMH Case Management Training Workgroup continues to hold four events each year. In FY 2007, one of the four was a conference entitled, "Well-Being and Recovery: Healthy Lifestyles for People with Mental Illness." Another training, "Working with Individuals with Diverse Gender Identity or Expression," expanded case managers competencies in working with youth and adults in a high risk sub-culture. DMH was also able to provide statewide training on transition age youth topics presented by nationally recognized trainers. DMH continues to provide difficult-to-treat and psychopharmacology case consultations, upon request, through its Area Medical Directors and Child/Adolescent Medical Directors. Although statewide conferences have been curtailed in recent years due to budget constraints, the individual Areas continue to hold conferences on such topics as varied as cultural diversity, women's issues, health and wellness, elder mental health issues and ethics.

Massachusetts

Adult - Emergency Service Provider Training

Adult - Provides for training of providers of emergency health services regarding mental health;

Criterion 5: Management Systems

Emergency Service Provider Training

Effective intervention requires a coordinated response from all those involved in identifying people with mental illness across the continuum of care, including those who may be involved in a crisis response. Work is being developed across DMH Areas related to disaster planning and needed training and implementation plans. Providers have been engaged in discussions related to disaster planning and implementation. In the Southeastern Area's Taunton/Attleboro Site, for example, cross agency participation in training exercises among those who are most likely to interact in emergency situations has been quite successful. Police and other first responder trainings in that Area have been quite successful.

The DMH Forensic Mental Health Service system provides specialized training for court clinicians, DMH staff and staff of community-based service providers. DFMH partners with the Law and Psychiatry research and training program of the University of Massachusetts Medical School to provide specialized forensic training for clinicians involved in court clinics and those providing inpatient forensic examinations for both juveniles and adults in the public sector forensic mental health system. A training series is offered annually for those clinicians who are seeking designation as Designated Forensic Professionals, as well as those clinicians who will be engaged in court-related evaluation and consultation efforts. The curriculum for that training, which is supplemented with videotape case examples, includes: The Massachusetts Social Service System; Legal Systems; Statutes and State/Federal Regulations; Cultural Awareness for Working with Forensic Populations; Ethical Issues in Adult and Juvenile Forensic Services; Violence Risk Assessment; Expert Testimony; and General Report Writing. The training also includes information related to assessing persons who may be at risk of harm to themselves or others related to substance use and/or mental illness. Such evaluations often take place in court clinic settings, and court clinicians (comprised of both DMH employees and provider staff communities) are well-positioned to respond to local evaluations requested in an acute emergency context. In addition, although not specific to emergency preparedness, a state-wide in-service training for mental health professionals working in forensic contexts is provided at least annually.

Training for community-based service providers, law enforcement, probation, emergency service teams, parole and others provided through the partnership with UMass Medical School Law and Psychiatry have included a cross-training on community re-entry and vocational readiness for ex-offenders, violence risk assessment, working with adolescents, jail diversion, psychopharmacology and working with clients who are difficult to engage in treatment. Also, there have been trainings of psychologists and psychiatrists and other staff working in correctional settings related to mental health services and the assessment of someone who may be in need of emergency psychiatric evaluation and inpatient psychiatric assessment. The forensic training curriculum, which incorporates these various training initiatives, is reviewed on an ongoing basis.

DMH and the Department of Public Health (DPH) continue their close collaboration in the area of behavioral health. Since the tragic events of September 11, 2001, the two agencies have worked to enhance the overall emergency response capabilities in the areas of providing mental health and substance abuse services during

times of disaster. This partnership includes integrating behavioral health into all phases of emergency response, including planning, rescue and recovery from emergency events. The state has worked to develop and maintain behavioral health capabilities at all levels of government, focusing closely on interagency integration at the local community level through the HRSA Bioterrorism, now the Office of Assistant Secretary for Preparedness and Response (ASPR), Hospital Preparedness grant. DMH and DPH together have developed a menu of trainings in psychosocial issues specific to a variety of audiences, with a focus on healthcare, including primary care providers, emergency room personnel, public health and emergency management officials. Training has included a focus on at-risk, special needs populations, particularly in assisting affected community members in the area of disaster behavioral health.

Massachusetts

Adult - Grant Expenditure Manner

Adult - Describes the manner in which the State intends to expend the grant under Section 1911 for the fiscal years involved

Criterion 5: Management Systems

Grant Expenditure Manner

The block grant represents about 1.9 % of the projected SFY'09 total budget support for community mental health services. These funds are targeted to a range of community mental health programs for adults with serious mental illness and children and adolescents with serious emotional disturbance. Services supported by the block grant are an integral part of the community mental health service delivery system and an important means of developing a comprehensive service system for all individuals in need of publicly funded care.

The following tables provide a description of state activities under the block grant and a projection of block grant spending for FFY'09. Block Grant funds are awarded on a federal fiscal year basis and the state has two years in which to obligate and expend the funds. Block grant funds are expended on the state fiscal year (SFY) cycle (July 1 to June 30) which differs from the federal fiscal year (October 1 to September 30).

Table One shows the specific services purchased with block grant funds, including child and adolescent services. DMH has allocated $2.49 million of the grant for FFY'09 for child/adolescent services and continues to comply with the allocation set-aside for these clients. In addition, the state has ensured that when it comes to state expenditures, the level of services allocated for children and adolescents has been maintained.

Table Two indicates the service delivery areas involved. Proposals and contracts for these funds and services will be developed in anticipation of the awarding of the grant.

The administrative component of the block grant is used to support Planning Council activities and perform administrative and accountability functions, such as the development of prevalence estimates and mechanisms for monitoring program accountability and expenditures of block grant funds.

TABLE ONE

FFY'09 PROJECTED BLOCK GRANT SPENDING PLAN (Page 134)

Program Code	Description	FFY 09 %	Projected FFY 09 Funding
3007	Program Management	1.01%	$ 80,000.00
	Subtotal Administration	1.01%	$ 80,000.00
3039	Homeless Support Services	0.38%	$ 29,698.00
3034	Clubhouse Services	6.96%	$ 548,988.00
3049	Adult Residential Services	18.41%	$ 1,452,245.00
3048	Respite Care Services	10.26%	$ 809,431.00
3036	Services for Education and Employment	8.63%	$ 680,750.00
3037	Day Rehabilitation	0.38%	$ 30,156.00
3056	Individual Support	0.35%	$ 27,413.00
3031	Program of Assertive Community Treatment	1.27%	$ 99,847.00
3050	Contracted Adult Outpatient Services	0.15%	$ 11,985.00
3075	Individual Support/Residential	1.22%	$ 95,927.00
3059	Community Rehabilitative Support	13.97%	$ 1,101,936.00
	Subtotal Adult Services	61.96%	$ 4,888,376.00
3064	Contracted Child/Adolescent OutPatient Services	0.00%	$ -
3065	Community & School Support	16.13%	$ 1,272,994.00
3066	Individual and Family Flexible Support	13.92%	$ 1,098,552.00
3068	Day Services	0.58%	$ 45,423.00
3078	Child/Adolescent Respite Care	0.00%	$ -

3079	Child/Adolescent Residential Service	1.05%	$ 82,687.00
	Subtotal Children's Services	31.68%	$ 2,499,656.00
3015	Client & Community Empowerment	1.77%	$ 139,354.00
3020	Comprehensive Staff Training	0.96%	$ 76,000.00
3023	Research	1.20%	$ 95,000.00
3027	Adult Forensic Court Services	1.41%	$ 111,512.00
	Subtotal Mixed Services	5.35%	$ 421,866.00
	Total Services	100.00%	$ 7,889,898.00

TABLE TWO

FFY'09 BLOCK GRANT FUNDS SPENDING PLAN
BY AREA (Page 135)

WESTERN MASS AREA Elizabeth Sullivan, Area Director P.O. Box 389 Northampton, MA 01061 (413) 587-6295	Total FFY'09 Allocation	$ 469,444
CENTRAL MASS AREA Ann Scott, Area Director Worcester State Hospital 305 Belmont Street Worcester, MA 01604 (508) 368-3577	Total FFY'09 Allocation	$1,496,490
NORTHEAST AREA Sue Wing, Area Director P.O. Box 387 Tewksbury, MA 01876 (978) 863-5079	Total FFY'09 Allocation	$1,505,394
METRO BOSTON AREA Clifford Robinson, Area Director 85 East Newton Street Boston, MA 02118 (617) 626-9200	Total FFY'09 Allocation	$901,977
METRO SUBURBAN AREA Theodore Kirousis, Area Director Westboro State Hospital Lyman Street Westboro, MA 01581	Total FFY'09 Allocation	$1,868,737

TABLE TWO
(continued)

SOUTHEASTERN AREA Peter Evers, Area Director Brockton Multi-Service Center 165 Quincy Street Brockton, MA 02402 (508) 897-2020	Total FFY'09 Allocation	$1,320,699
STATEWIDE INITIATIVES Elaine Hill Central Office 25 Staniford Street Boston, MA 02114 (617) 626-8252	Total FFY'08 Allocation	$327,157
TOTAL:		**$7,889,898**

Table C. MHBG Funding for Transformation Activities
State: Massachusetts

	Column 1	Column 2	
	Is MHBG funding used to support this goal? If yes, please check	If yes, please provide the *actual* **or** *estimated* amount of MHBG funding that will be used to support this transformation goal in FY	
		Actual	**Estimated**
GOAL 1: Americans Understand that Mental Health Is Essential to Overall Health	☒		914188
GOAL 2: Mental Health Care is Consumer and Family Driven	☒		5168046.87
GOAL 3: Disparities in Mental Health Services are Eliminated	☐		
GOAL 4: Early Mental Health Screening, Assessment, and Referral to Services are Common Practice	☒		1396119.38
GOAL 5: Excellent Mental Health Care Is Delivered and Programs are Evaluated*	☒		897634.75
GOAL 6: Technology Is Used to Access Mental Health Care and Information	☐		
Total MHBG Funds	N/A	0	8375989

*Goal 5 of the Final Report of the President's New Freedom Commission on Mental Health states: Excellent Mental Health Care is Delivered and Research is Accelerated. However, Section XX of the MHBG statute provides that research … Therefore, States are asked to report expected MHBG expenditures related to program evaluation, rather than research.

Massachusetts

Table C - Description of Transformation Activities

For each mental health transformation goal provided in Table C, breifly describe transformation activities that are supported by the MHBG. You may combine goals in a single description if appropriate. If your State''s transformation activities are described elsewhere in this application, you may simply refer to that section(s).

Description of Transformation Activities - Child

Transitional Age Youth

Most young adults who have been served through the child/adolescent system aspire to independence. However, a key element of achieving this independence is developing the ability to find appropriate housing and acquiring and sustaining employment and other skills that will enhance their ability to live in the community. DMH recognizes the New Freedom Commission goals that Mental Health Care is Consumer and Family Driven and that Excellent Mental Health Care is Delivered and Research is Accelerated. With these goals in mind, DMH has expanded on initial pilots to develop a statewide approach to the development of programming for this age group. Supported housing, supported employment and case management have been redesigned to focus on the needs of the transition age youth population. Innovative and creative models across the Areas have highlighted the particular needs of the population for peer mentoring, job searching techniques, resume writing, interviewing skills, housing search techniques, social skills and budgeting. DMH is partnering with adolescents, young adults, parents and researchers in the development of this programming. Several examples of this partnership include:

- The creation of a Statewide Youth Coordinator position to work with the six DMH Area Youth Development Committees and Statewide Youth Advisory Committee.
- The Transformation Center, a peer-operated center, offers trainings and retreats in which youth and young adults learn the importance of peer networks and social connections in their transition to adulthood.

Involvement of pediatricians in early identification and treatment of mental health problems

Pediatricians are often the first resource that parents turn to for assistance, and they treat most of the less severe mental health problems. DMH supports several initiatives directly related to promoting the New Freedom Commission goals of making Americans Understand that Mental Health is Essential to Overall Health and Early Mental Health Screening, Assessment and Referral to Services are Common Practice. The Massachusetts Child Psychiatry Access Project (MCPAP), administered by MBHP with DMH funding, makes psychiatric consultation available to pediatric practices to improve primary care as it relates to mental health, to address concerns about psychiatric medication, and to assess the need for and assist in referrals to specialized mental health treatment. Seventy-eight percent of the pediatric practices in the state are enrolled. This service is offered free of charge to the pediatrician and thus is available for all children regardless of their insurance status. In the last year MCPAP built on that concept and piloted a consultation to schools. Additional funding to serve schools is expected to be approved for this fiscal year.

The availability of screening for mental health problems has expanded and is expected to increase even more in the next few years. Screening was a major focus of the Mental Health Commission for Children which issued its report in 2005. As noted in Health and Mental Health in Available Services, the Massachusetts Chapter of the American Academy of Pediatrics succeeded in securing agreements from the state's

major HMOs to reimburse for mental health screening. Screening for Medicaid members began December 31, 2007as screening was part of the Rosie D remedy.

Parents with Mental Illness and their Children

Attending to the needs of parents with mental illness is another example of how DMH recognizes the New Freedom Commission goals that Mental Health Care is Consumer and Family Driven and that Excellent Mental Health Care is Delivered and Research is Accelerated. Coming both through PAL, representing the parents of children with mental health problems, and consumers in the adult clubhouses, adults with varying degrees of mental health problems identified their need for assistance in parenting to address their own needs and to benefit their children who often had mental health problems. Most recently, the transition age youth have themselves identified the need for targeted assistance during pregnancy and in parenting and a resource guide targeted to this age group is being developed.

The Department of Children and Families and DMH have developed regionally based collaborative training programs and protocols to facilitate service plans that will provide parents with needed services and support. The new adult DMH eligibility form asks about parenting status on the face sheet, recognizing that all adults with mental illness, regardless of DCF involvement, may need support in their parenting role. DMH plans to specifically address parenting support in its future service procurements. Three inter-related parenting projects sponsored by Employment Options (a clubhouse) may provide evidence-based guidance. 1) The Family Options project for custodial parents provides care management for the entire family unit, both parent and child, and offers a resource center for families involved in the program. A partnership between a UMass Medical School Research Team and Employment Options, the project's grant-based funding supports research on its process and outcomes. An evidence-based documentary and discussion guide have been developed and a practice manual is in the planning stage. 2) The Clubhouse Family Project, for non-custodial parents, offers services such as visitation support, parenting education, home visits, service coordination, liaison with DCF, parent support groups, and advocacy that help parents gain the hands-on learning experience they need to acquire to use their parenting skills. 3) The Clubhouse Family Legal Support Project, now funded by DMH, the Massachusetts Bar Foundation and the Boston Bar Foundation, provides legal support to parents with mental illness to assist them in gaining visitation orders, increasing their visitation time with their children as well as maintaining and regaining custody of their children. DMH and UMass staff, as well as advocates from PAL, the Mental Health Legal Advisors Committee, and local service providers are active participants on an advisory committee exploring ways of broadening accessibility to the expertise developed by these projects and promoting statewide replication. Employment Options, working in partnership with the Heath Foundation of Central Massachusetts, has also created the Consulting and Training Project that offers an array of innovative trainings for parents, providers, and administrators, to support increased awareness and understanding of the strengths and needs of parents with mental illness, and the development of more family-centered, strengths-based services

Child and Adolescent Restraint Prevention Initiative

This effort began in 2001 with a focus on promoting strength-based care and reducing these coercive, high-risk procedures in child and adolescent acute and continuing care inpatient units and intensive residential treatment programs. As described in State Agency Leadership, DMH has used its contracting, licensing, and statutory authority and the collective teaching and practice change efforts organized through the initiative to lead to a significant statewide decline (85%) in seclusion and restraint use. This initiative was used as a template to develop the national curriculum to create violence-free and coercion-free treatment environments through NASMHPD's Technical Assistance Center (NTAC), and funded by the Center for Mental Health Services at SAMHSA. Several DMH staff were NTAC founding teaching faculty and have worked with NASMHPD to advance this effort nationally and internationally. These results represent significant progress towards the NFC goals that Mental Health Care is Consumer and Family Driven and that Excellent Mental Health Care is Delivered and Research is Accelerated.

Eligibility Process

In 2007, DMH reviewed data on the percentage of individuals who apply for DMH services and are found eligible, the number of days between receipt of an eligibility application and decision, and reasons for denial. This review found that variability existed among the Areas in regards to the percentage found eligible and in the turnaround time between application receipt and decision. Furthermore, a significant percentage of individuals were not determined eligible because their applications were either withdrawn or not fully initiated.

As a result of this data review and in support of the New Freedom Commission goals that Referral to Services is Common Practice and Mental Health Care is Consumer and Family Driven, DMH instituted several eligibility process changes. These changes are designed to streamline paperwork, link consumers and family members with appropriate services in a more efficient manner, and provide consumers and family members with a user-friendly process that focuses on their desired outcomes and goals. The changes to the process include:

- Simplified Request for Services forms;
- telephone outreach to engage applicants and their families, as appropriate, and assess their needs; and
- face-to-face meetings with adult applicants and their families to increase engagement and, as appropriate, further assess and collect information necessary to make eligibility determinations. The child and adolescent process already included this component.

Data Systems

DMH has completed implementation of its Mental Health Information System (MHIS), involving customization of a commercially available software system to fit DMH's unique clinical and business environments. This is a multi-faceted system that has applications in both hospitals (administrative systems and an electronic medical record) and the community (care management). The ability to capture information about all of the services received by a DMH client has been greatly enhanced, with the caveat

that DMH must still develop an effective and consistent way of entering data for clients who do not receive state-operated case management services.

In addition to MHIS, other division-specific data tracking systems exist for Investigations, Contracting, Child and Adolescent Statewide programs, Housing, Employment, and Seclusion and Restraint.

All of DMH's systems incorporate safeguards regarding client confidentiality, with access granted strictly on a need-to-know basis. DMH maintains a "Security and Confidentiality Policy for DMH Computerized Information Systems Containing Client Records or Data" to further ensure that strict standards are in place. In addition, DMH also implemented HIPAA regulations regarding privacy of client information.

With MHIS fully implemented and in recognition of the New Freedom Commission goal that Technology is Used to Access Mental Health Care and Information, DMH is now focusing resources on the development of reports and integrated databases for the purposes of program management, quality improvement and state and federal reporting. Examples of this work include:

- **INFORM Reports System:** The INFORM Reports System is a secure, user-friendly application utilizing DMH and the Department of Public Health Meditech data (MHIS) stored in the DMH Data Warehouse regarding DMH clients. This system now has over 90 reports and a history of service function. It addresses the needs of DMH managers for information related to census, waitlists, and lengths of stay across the continuum of care, as well as information on the demographic, insurance profiles and diagnostic picture of DMH clients.
- **DMH Community Indicator Report**: The second phase in the development of DMH's management indicator reports is focused on both the community system and the interface between the inpatient and community systems. This report is currently being developed. To the extent possible, individual indicators will be consistent with the National Outcome Measures and provide data for the State Mental Health Plan.
- **DMH Admissions Referral Tracking (DART) System:** The (DART) System is a web-based data entry system and reports module. It is designed to capture relevant information about all referrals to DMH continuing care units in real time, provide standardized reports and eliminate multiple and duplicative requests for information. This system was fully implemented in June 2007.

Children's Behavioral Health Initiative

Many opportunities for system integration are being created as the state responds to the Rosie D lawsuit. Implementation of the remedy for that lawsuit is now conceived of as the first phase of a broad Children's Behavioral Health Initiative. Four New Freedom Commission goals are being addressed: Mental Health Care is Consumer and Family Driven; Disparities in Mental Health Services are Eliminated; Early Mental Health Screening, Assessment and Referral to Services are Common Practice, and Excellent Mental Health Care is Delivered and Research is Accelerated. Although the lawsuit was about MassHealth services and did not formally involve any other agency, DMH has been involved with Mass Health, DYS,DCF and DPH in all aspects of planning for implementation of the order, including activities related to screening, assessment, intensive care coordination, services, and the information interface. The

remedy calls for every Mass Health member under age 21who is eligible for Early Periodic Screening, Diagnosis and Treatment (EPSDT) services to receive periodic screenings through a medical practice, to be offered assessment by a mental health clinician if a certain screening threshold is met, to receive a comprehensive assessment, and to be referred to such services as medically necessary, including intensive care coordination provided in accord with Wraparound principles. The judge's order requires state agencies to participate in the intensive care coordination team which is to lead to a single plan of care for each child. The order also calls for the state to establish Community Service Agencies (CSAs) in sites across the state to provide intensive care coordination. Although the state agencies now have most of their geographic service boundaries in common, the need to create geographically defined CSAs affords an opportunity for each agency to align its boundaries with those of the CSA. The state agencies are meeting regularly in an interagency workgroup to review their current services and service delivery systems to align their services with those being provided with the remedy and to implement strategies to reduce fragmentation and duplication, and prevent discontinuities of care if a child loses Mass Health coverage.

Providing Psychiatric Consultation to the Department of Children and Families

Although children involved with DCF have access to mental health treatment, usually through MassHealth, DCF as an agency has not had its own psychiatrists to increase the knowledge base of its staff and to consult to staff on difficult cases. Addressing the New Freedom Commission goal of Excellent Mental Health Care is Delivered and Research is Accelerated, DMH has allocated some of the time of its child psychiatrists to work with the local offices of DCF, and is working with DCF to identify strategies to maximize the benefit of that consultation.

Preventing Homelessness among Transition Age Youth

Historically, DMH housing has focused on the adult population and has not had age appropriate housing options for older adolescents and young adults. The Youth Development Committee of the Planning Council and the local Youth Advisory Councils have advocated for increasing the number of housing options available to transition age youth. In support of the New Freedom Commission goal that Disparities in Mental Health Services are Eliminated, Area Housing Coordinators have been linked with the point people for transition age youth and the Young Adult Advisory Council to increase the number of housing choices available to transition age youth. DMH is engaged in collaborative planning with the Department of Children and Families to assist them in planning for youth in their care and custody who have mental health problems and will be aging out of DCF custody.

ADULT - GOALS TARGETS AND ACTION PLANS

Transformation Activities: ☑

Name of Performance Indicator: Increased Access to Services (Number)

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Fiscal Year	FY 2006 Actual	FY 2007 Actual	FY 2008 Projected	FY 2009 Target	FY 2010 Target	FY 2011 Target
Performance Indicator	17,126	17,626	18,035	17,800	17,800	17,800
Numerator	N/A	N/A	--	--	--	--
Denominator	N/A	N/A	--	--	--	--

Table Descriptors:

Goal: Maintain the number of DMH eligible adult clients receiving a continuing care community mental health service

Target: At least 17,100 DMH adult clients will receive a continuing care community mental health service each fiscal year

Population: DMH eligible adult clients

Criterion: 2:Mental Health System Data Epidemiology
3:Children"s Services

Indicator: # of DMH adult clients receiving a community service during each fiscal year

Measure: # of DMH adult clients receiving a community service during each fiscal year

Sources of Information: DMH Data Warehouse

Special Issues: This indicator does not include DMH eligible adult clients receiving inpatient services only. DMH periodically runs data quality reports on its Mental Health Information System (MHIS) to ensure that clients are appropriately enrolled in services. When clients are no longer receiving services from DMH, the person is discharged from DMH. As a part of continuous efforts to ensure quality, periodic reviews are done and documentation is updated. Some annual variation in data is related to ongoing efforts to improve data integrity. Actual costs and availablity of state revenues may impact these estimates.

Significance: DMH’s enrolled population refers to those who apply for and are determined eligible for DMH continuing care community services, for whom no other options, outside of DMH, exist. DMH services include residential, PACT, case management, day, outpatient, educational and employment services, and other community services, such as community rehabilitation support. After being found eligible to receive DMH community services, each individual is assigned to services according to priority of need. If no appropriate community service is available, the individual is placed on a waiting list and is contacted on a regular basis regarding wait status. Access and availability of services are high priorities for DMH.

Action Plan: This indicator will be included in a monthly Community Indicator Report which will be made available to DMH managers, with the expectation that managers utilize this data for program management and quality improvement purposes. The eligibility determination process was changed in 2007 to be more user-friendly with earlier phone and face-to-face contact and a simplified Request for Services form. Although these changes are not expected to increase the number of eligible clients as the eligibility criteria remain the same, the number of DMH eligible clients receiving a continuing care community mental health service increased slightly in FY2008. DMH will continue to monitor the impact of this change.

ADULT - GOALS TARGETS AND ACTION PLANS

Transformation Activities: ☑

Name of Performance Indicator: Reduced Utilization of Psychiatric Inpatient Beds - 30 days (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Fiscal Year	FY 2006 Actual	FY 2007 Actual	FY 2008 Projected	FY 2009 Target	FY 2010 Target	FY 2011 Target
Performance Indicator	10.49	4.79	8	8	7	7
Numerator	62	24	--	--	--	--
Denominator	591	501	--	--	--	--

Table Descriptors:

Goal: Increase community tenure of DMH eligible adult clients

Target: To increase community tenure by reducing the 30-day readmission rate of DMH adult (non-forensic) clients to state-operated inpatient facilities to 7% by FY2010.

Population: DMH adult (non-forensic) clients discharged from state-operated inpatient facilities

Criterion: 1:Comprehensive Community-Based Mental Health Service Systems
3:Children"s Services

Indicator: % of DMH (non-forensic) clients discharged from state-operated inpatient facilities who are readmitted to a state-operated facility within 30 days of discharge

Measure: # of DMH (non-forensic) adults readmitted to state-operated inpatient facilities within 30 days of discharge/# of DMH (non-forensic) adults discharged from state-operated inpatient facilities.

Sources of Information: DMH Data Warehouse

Special Issues: Most admissions to state hospitals occur after one or more acute inpatient (community) hospitalizations. The 30-day readmission rate to state-operated facilities does not represent the hospitalization experience of DMH clients as a readmission will most likely take place in an acute care facility. At this time, DMH has limited availability of Mass Health readmission data.

Significance: The monitoring of readmission rates has achieved high priority within DMH with the increased focus on the integration of acute and continuing care behavioral health services. There are several current initiatives aimed at improving the linkage between private acute-care facilities and state-operated inpatient facilities.

Action Plan: The Readmission Collaborative, formed in November 2006, has been developing and implementing strategies aimed to reduce acute-care inpatient readmission rates of DMH clients who receive acute-care Mass Health benefits through the Massachusetts Behavioral Health Partnership (MBHP). DMH has also developed a standardized application for continuing care admissions as well as a web-based admission referral tracking database.

ADULT - GOALS TARGETS AND ACTION PLANS

Transformation Activities: ☑

Name of Performance Indicator: Reduced Utilization of Psychiatric Inpatient Beds - 180 days (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Fiscal Year	FY 2006 Actual	FY 2007 Actual	FY 2008 Projected	FY 2009 Target	FY 2010 Target	FY 2011 Target
Performance Indicator	18.10	10.78	14	14	13	12
Numerator	107	54	--	--	--	--
Denominator	591	501	--	--	--	--

Table Descriptors:

Goal: Increase community tenure of DMH adult clients

Target: To increase community tenure by reducing the 180-day readmission rate of DMH adult (non-forensic) clients to state-operated inpatient facilities by 1% each year

Population: DMH adult (non-forensic) clients discharged from state-operated inpatient facilities

Criterion: 1:Comprehensive Community-Based Mental Health Service Systems
3:Children"s Services

Indicator: % of DMH (non-forensic) clients discharged from state-operated inpatient facilities who are readmitted to a state-operated facility within 180 days of discharge

Measure: # of DMH (non-forensic) adults readmitted to state-operated inpatient facilities within 180 days of discharge/# of DMH (non-forensic) adults discharged from state-operated inpatient facilities.

Sources of Information: DMH Data Warehouse

Special Issues: Most admissions to state hospitals occur after one or more acute inpatient (community) hospitalizations. The 180-day readmission rate to state-operated facilities is low and does not represent the hospitalization experience of DMH clients as most readmissions will take place in an acute-care facility. At this time, DMH has limited availability of Mass Health readmission data.

Significance: The monitoring of readmission rates has achieved high priority within DMH with the increased focus on the integration of acute and continuing care behavioral health services. There are several current initiatives aimed at improving the linkage between private acute-care facilities and state-operated inpatient facilities.

Action Plan: The Readmission Collaborative, formed in November 2006, has been developing and implementing strategies aimed to reduce acute-care inpatient readmission rates of DMH clients who receive acute-care Mass Health benefits through the Massachusetts Behavioral Health Partnership (MBHP). DMH has also developed a standardized application for continuing care admissions as well as a web-based admission referral tracking database.

ADULT - GOALS TARGETS AND ACTION PLANS

Transformation Activities: ☐

Name of Performance Indicator: Evidence Based - Adults with SMI Receiving Supported Housing (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Fiscal Year	FY 2006 Actual	FY 2007 Actual	FY 2008 Projected	FY 2009 Target	FY 2010 Target	FY 2011 Target
Performance Indicator	24.47	24.23	24	24	24	24
Numerator	4,190	4,270	--	--	--	--
Denominator	17,126	17,626	--	--	--	--

Table Descriptors:

Goal: Maintain the percentage of DMH eligible adult clients receiving supported housing

Target: To provide supported housing services to 24% of DMH eligible adult clients who receive a DMH continuing care community mental health service each fiscal year

Population: DMH eligible adult clients receiving a DMH continuing care community mental health service

Criterion: 1:Comprehensive Community-Based Mental Health Service Systems
3:Children"s Services

Indicator: % of DMH adult clients receiving supported housing services

Measure: # of DMH adult clients receiving supported housing services/# of DMH adult clients receiving a DMH continuing care community mental health service

Sources of Information: DMH Data Warehouse

Special Issues: None

Significance: Supported housing services are provided within a range of community residential services for individuals with serious mental illness. These services are provided flexibly to allow individuals to receive the appropriate level of services, such as support, supervision, treatment and rehabilitation, depending on their specific and changing needs.

Action Plan: This service is currently being reviewed as a part of the current community-based services reprocurement process as noted in the Executive Summary. DMH is currently soliciting feedback through a Request for Information. DMH intends to continue to offer flexible, community-based supportive and rehabilitative services.

ADULT - GOALS TARGETS AND ACTION PLANS

Transformation Activities: ☑

Name of Performance Indicator: Evidence Based - Adults with SMI Receiving Supported Employment (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Fiscal Year	FY 2006 Actual	FY 2007 Actual	FY 2008 Projected	FY 2009 Target	FY 2010 Target	FY 2011 Target
Performance Indicator	7.68	7.27	7	7	7	7
Numerator	1,315	1,281	--	--	--	--
Denominator	17,126	17,626	--	--	--	--

Table Descriptors:

Goal: Maintain the percentage of DMH eligible adult clients receiving supported employment

Target: To provide supported employment services to 7% of DMH adult clients receiving a DMH continuing care community mental health service each fiscal year

Population: DMH eligible adult clients receiving a continuing care community mental health service

Criterion: 1:Comprehensive Community-Based Mental Health Service Systems
3:Children"s Services

Indicator: % of DMH adult clients receiving supported employment services

Measure: # of DMH adult clients receiving supported employment services/# of DMH adult clients receiving a DMH continuing care community mental health service

Sources of Information: DMH Data Warehouse

Special Issues: The Services for Education and Employment (SEE) program of DMH consists of 25 local programs in communities across the state. DMH adult clients are offered flexible, individualized supports with the goal of producing permanent employment with mainstream employers. Education and/or training placements are also offered, with the intent of better preparing clients to enter into competitive employment. Although fidelity to the Supported Employment model is not a requirement of the Department's SEE contracts, fidelity is encouraged. It is important to note that Supported Employment services are provided through other program models, such as Clubhouses, however, unduplicated data are not available.

Significance: The majority of DMH clients and others with mental illness in the community are unemployed or under-employed. To address this, DMH sponsors community-based programs to assist clients with achieving employment or educational objectives. The goal is to further a client?s recovery process as well as his or her economic well-being.

Action Plan: DMH continues to fund supported employment through the Services for Education and Employment (SEE) contracts. DMH is currently collaborating with the Center for Health Policy & Research at the University of Massachusetts in a research and technical assistance project to examine and enhance the performance of SEE programs. In addition, the Executive Office of Health and Human Services (EOHHS) is in the process of leading a secretariat-wide employment procurement. DMH is currently evaluating how best to incorporate the EOHHS initiative to improve employment opportunities and outcomes for DMH clients.

ADULT - GOALS TARGETS AND ACTION PLANS

Transformation Activities: ☑

Name of Performance Indicator: Evidence Based - Adults with SMI Receiving Assertive Community Treatment (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Fiscal Year	FY 2006 Actual	FY 2007 Actual	FY 2008 Projected	FY 2009 Target	FY 2010 Target	FY 2011 Target
Performance Indicator	4.67	4.69	4.50	4.50	4.50	4.50
Numerator	799	826	--	--	--	--
Denominator	17,126	17,626	--	--	--	--

Table Descriptors:

Goal: Maintain the percentage of DMH eligible adult clients receiving Assertive Community Treatment

Target: To maintain the percentage of DMH adult clients receiving Assertive Community Treatment through DMH's Program of Assertive Community Treatment (PACT)

Population: DMH eligible adult clients receiving a DMH continuing care community mental health service

Criterion: 1:Comprehensive Community-Based Mental Health Service Systems
3:Children"s Services

Indicator: % of DMH adult clients receiving Assertive Community Treatment

Measure: # of DMH adult clients receiving Assertive Community Treatment/# of DMH adult clients receiving a DMH continuing care community mental health service

Sources of Information: DMH Data Warehouse

Special Issues: Presently there are 15 PACT programs across the state serving approximately 850 individuals. Consistent with the ACT model, clients' engagement in the program is long-term and continuous. Thirteen of the programs are at or near full census. Two new teams were started in the Southeastern Area in FY 2008. Each program is expected to enroll approximately two to four clients per month until reaching a capacity of 60 clients.

Significance: PACT is currently the only evidence-based practice funded by DMH for which fidelity to the model is a contractual expectation and fidelity is monitored. DMH has a part-time coordinator of PACT services in Central Office and also utilizes an ACT consultant.

Action Plan: The role of the PACT coordinator is to monitor and promote the PACT teams' adherence and fidelity to the model and utilization of other evidence-based practices under the umbrella of the program. In addition to periodic fidelity assessments, meetings with PACT team specialists are held to share statewide resources, best practices and provide training. The ACT consultant provides individualized consultation, training and role modeling to teams based on assessments of the program and their requests. In addition, statewide trainings are held in collaboration with the Massachusetts Behavioral Health Partnership (MBHP).

ADULT - GOALS TARGETS AND ACTION PLANS

Transformation Activities: ☐ **Indicator Data Not Applicable:** ☑

Name of Performance Indicator: Evidence Based - Adults with SMI Receiving Family Psychoeducation (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Fiscal Year	FY 2006 Actual	FY 2007 Actual	FY 2008 Projected	FY 2009 Target	FY 2010 Target	FY 2011 Target
Performance Indicator	N/A	N/A	N/A	N/A	N/A	N/A
Numerator	N/A	N/A	--	--	--	--
Denominator	N/A	N/A	--	--	--	--

Table Descriptors:

Goal:

Target:

Population:

Criterion: 1:Comprehensive Community-Based Mental Health Service Systems
3:Children"s Services

Indicator:

Measure:

Sources of Information:

Special Issues: While individual programs in the state may be providing family psychoeducation, DMH does not currently monitor or directly fund this evidence-based practice.

Significance:

Action Plan:

ADULT - GOALS TARGETS AND ACTION PLANS

Transformation Activities: ☐ **Indicator Data Not Applicable:** ☑

Name of Performance Indicator: Evidence Based - Adults with SMI Receiving Integrated Treatment of Co-Occurring Disorders(MISA) (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Fiscal Year	FY 2006 Actual	FY 2007 Actual	FY 2008 Projected	FY 2009 Target	FY 2010 Target	FY 2011 Target
Performance Indicator	N/A	N/A	N/A	N/A	N/A	N/A
Numerator	N/A	N/A	--	--	--	--
Denominator	N/A	N/A	--	--	--	--

Table Descriptors:

Goal:

Target:

Population:

Criterion: 1:Comprehensive Community-Based Mental Health Service Systems
3:Children"s Services

Indicator:

Measure:

Sources of Information:

Special Issues: While residential programs funded by DMH are required to provide integrated treatment for clients with co-occurring disorders, DMH does not require or monitor fidelity to the evidence-based practice.

Significance:

Action Plan:

ADULT - GOALS TARGETS AND ACTION PLANS

Transformation Activities: ☐ **Indicator Data Not Applicable:** ☑

Name of Performance Indicator: Evidence Based - Adults with SMI Receiving Illness Self-Management (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Fiscal Year	FY 2006 Actual	FY 2007 Actual	FY 2008 Projected	FY 2009 Target	FY 2010 Target	FY 2011 Target
Performance Indicator	N/A	N/A	N/A	N/A	N/A	N/A
Numerator	N/A	N/A	--	--	--	--
Denominator	N/A	N/A	--	--	--	--

Table Descriptors:

Goal:

Target:

Population:

Criterion: 1:Comprehensive Community-Based Mental Health Service Systems
3:Children"s Services

Indicator:

Measure: While individual programs in the state may be providing illness self management, DMH does not currently monitor or directly fund this evidence-based practice.

Sources of Information:

Special Issues:

Significance:

Action Plan:

ADULT - GOALS TARGETS AND ACTION PLANS

Transformation Activities: ☐ **Indicator Data Not Applicable:** ☑

Name of Performance Indicator: Evidence Based - Adults with SMI Receiving Medication Management (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Fiscal Year	FY 2006 Actual	FY 2007 Actual	FY 2008 Projected	FY 2009 Target	FY 2010 Target	FY 2011 Target
Performance Indicator	N/A	N/A	N/A	N/A	N/A	N/A
Numerator	N/A	N/A	--	--	--	--
Denominator	N/A	N/A	--	--	--	--

Table Descriptors:

Goal:

Target:

Population:

Criterion: 1:Comprehensive Community-Based Mental Health Service Systems
3:Children"s Services

Indicator:

Measure:

Sources of Information:

Special Issues: While individual programs/clinics in the state may be providing medication management, DMH does not currently monitor or directly fund this evidence-based practice.

Significance:

Action Plan:

ADULT - GOALS TARGETS AND ACTION PLANS

Transformation Activities: ☐

Name of Performance Indicator: Client Perception of Care (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Fiscal Year	FY 2006 Actual	FY 2007 Actual	FY 2008 Projected	FY 2009 Target	FY 2010 Target	FY 2011 Target
Performance Indicator	69.62	70.30	71	72	73	74
Numerator	110	142	--	--	--	--
Denominator	158	202	--	--	--	--

Table Descriptors:

Goal: To increase client perception of care

Target: To increase the percentage of DMH adult clients receiving case management services who report positively about their outcomes on the annual consumer and family member satisfaction survey by 1% each year

Population: DMH adult clients receiving case management services

Criterion: 1:Comprehensive Community-Based Mental Health Service Systems
3:Children"s Services

Indicator: % of DMH adult clients receiving case management services reporting positively about outcomes on the annual consumer and family member satisfaction survey

Measure: # of DMH adult clients receiving case management services reporting positively about outcomes on the annual consumer and family member satisfaction survey/# of DMH adult clients receiving case management services completing the outcomes section of the annual consumer and family member satisfaction survey

Sources of Information: Annual Consumer and Family Member Satisfaction Survey

Special Issues: In 2006, DMH initiated an annual statewide Consumer and Family Member Satisfaction Survey. DMH contracted with the Center for Mental Health Services Research (CMHSR) at the University of Massachusetts to conduct this survey. Utilizing the MHSIP Consumer Survey tool, a random sample of DMH clients and family members are stratified by program type each year. Adults receiving case management services and family members of children/adolescents receiving case management services are included in the survey each year in order to maintain a consistent population for establishing benchmarks and targets. Therefore, it is important to note that while the survey samples several program types, only adults receiving case management services are included in the denominator of this goal.

Significance: DMH initiated an annual statewide consumer and family member satisfaction survey in 2006 in order to meet federal reporting requirements and to provide data for program management and quality improvement purposes. DMH recognizes the importance of this survey in providing valuable information on the experience and outcomes of individuals who receive services provided by DMH.

Action Plan: DMH is currently conducting its third annual Consumer and Family Member Satisfaction Survey. A DMH advisory group is working with CMHSR to further refine the survey methodology, improve response rates to provide valid data to meet reporting requirements, and inform program management and quality improvement efforts. In 2008, meetings were held with Central Office and Area leadership to identify areas for further data analysis and to identify opportunities for Area and statewide improvement.

ADULT - GOALS TARGETS AND ACTION PLANS

Transformation Activities: ☑

Name of Performance Indicator: Adult - Increase/Retained Employment (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Fiscal Year	FY 2006 Actual	FY 2007 Actual	FY 2008 Projected	FY 2009 Target	FY 2010 Target	FY 2011 Target
Performance Indicator	N/A	12.90	8	9	10	11
Numerator	N/A	1,146	--	--	--	--
Denominator	N/A	8,885	--	--	--	--

Table Descriptors:

Goal: Increase the percentage of DMH eligible adult (age 26 to 64) clients who are employed.

Target: To increase the percentage of DMH adult (age 26 to 64) clients receiving case management services who are employed by 1% each fiscal year

Population: DMH eligible adults (age 26 to 64) receiving case management services

Criterion: 1:Comprehensive Community-Based Mental Health Service Systems

Indicator: % of DMH adult clients (age 26 and above) receiving case management services who are employed

Measure: # of DMH adult clients (age 26 and above) receiving case management services who are employed/# of DMH adult clients (age 26 and above) receiving case management services

Sources of Information: DMH Data Warehouse

Special Issues: Currently, the DMH Mental Health Information System (MHIS) captures data on employment for DMH clients receiving case management services only. Therefore, this indicator underrepresents the true number of DMH adult clients who are employed because it does not provide a count of individuals who are enrolled in all DMH-funded employment programs or who may be working. Employment for this indicator is defined as part-time, full-time, supported or self employment. The employment sub-committee of the Planning Council advocates for the inclusion of volunteer work in this definition, however the data reported in this indicator are consistent with the definition. Data are not collected within MHIS on job tenure. Data for FY 2006 are not available. Employment data for DMH eligible clients ages 16-25 receiving case management services are reported as a separate performance indicator.

Significance: DMH recognizes employment as an important component of recovery as well as a means of achieving self sufficiency. Employment services are offered through several DMH funded programs, including clubhouses, Services for Education and Employment, and Program of Assertive Community Treatment. In addition to DMH's focus on employment, the Employment sub-committee of the Planning Council has been advocating for increased access to employment support services. Employment has been identified as a primary goal of the Governor and Secretary and as a consumer outcome in the Quality Framework developed by DMH's Quality Council.

Action Plan: DMH plans to develop an Employment Assessment within MHIS to collect additional data on employment. This employment indicator will also be added to the DMH Community Indicator Report. This monthly report is currently being developed and will serve as a program management and quality improvement tool for DMH managers. In addition, DMH is participating in several interagency initiatives related to improving outcomes of individuals served by the Executive Office of Health and Human Services (EOHHS) and DMH.

ADULT - GOALS TARGETS AND ACTION PLANS

Transformation Activities: ☑

Name of Performance Indicator: Adult - Decreased Criminal Justice Involvement (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Fiscal Year	FY 2006 Actual	FY 2007 Actual	FY 2008 Projected	FY 2009 Target	FY 2010 Target	FY 2011 Target
Performance Indicator	57.14	80	72	73	74	75
Numerator	4	8	--	--	--	--
Denominator	7	10	--	--	--	--

Table Descriptors:

Goal: To increase the percentage of DMH eligible adult clients who are not involved in the criminal justice system

Target: To increase the percentage by 1% each year of DMH adult clients receiving case management services who demonstrate less involvement in the criminal justice system by not being arrested following an initial arrest as reported on the annual consumer and family member satisfaction survey

Population: DMH eligible adult clients receiving case management services

Criterion: 1:Comprehensive Community-Based Mental Health Service Systems
3:Children"s Services

Indicator: % of DMH adult clients receiving case management services were arrested and not rearrested in the last 12 months or since beginning services as reported on the annual consumer and family member satisfaction survey

Measure: # of DMH adult clients receiving case management services who were arrested and not rearrested in the last 12 months or since beginning services as reported on the annual consumer and family member satisfaction survey/# of DMH clients receiving case management services who were arrested in the last 12 months or since beginning services as reported on the annual consumer and family member satisfaction survey

Sources of Information: Annual Consumer and Family Member Satisfaction Survey

Special Issues: In 2006, DMH initiated an annual statewide Consumer and Family Member Satisfaction Survey. DMH contracted with the Center for Mental Health Services Research (CMHSR) at the University of Massachusetts to conduct this survey. Utilizing the MHSIP Consumer Survey tool, a random sample of DMH clients and family members are stratified by program type each year. Adults receiving case management services and family members of children/adolescents receiving case management services are included in the survey each year in order to maintain a consistent population for establishing benchmarks and targets. Therefore, it is important to note that while the survey samples several program types, only adults receiving case management services are included in the denominator of this goal. Administrative data regarding arrests and criminal justice involvement are not currently available.

Significance: DMH initiated an annual statewide consumer and family member satisfaction survey in 2006 in order to meet federal reporting requirements and to provide data for program management and quality improvement purposes. DMH recognizes the importance of this survey in providing valuable information on the experience and outcomes of individuals who receive services provided by DMH.

Action Plan: DMH is currently conducting its third annual Consumer and Family Member Satisfaction

Survey. A DMH advisory group is working with CMHSR to further refine the survey methodology, improve response rates to provide valid data to meet reporting requirements, and inform program management and quality improvement efforts. In 2008, meetings were held with Central Office and Area leadership to identify areas for further data analysis and to identify opportunities for Area and statewide improvement. Through its Division of Forensic Mental Health (DFMH), DMH has instituted a system of adult court clinics, conducts forensic evaluations and case consultations to the courts and has established a statewide Forensic Transition Team (FTT). In particular, FTT has been identified by DMH as a best practice for its work in preparing inmates with serious mental illness for discharge and community re-entry. DFMH has also established five pre-arrest jail diversion programs.

ADULT - GOALS TARGETS AND ACTION PLANS

Transformation Activities: ☑

Name of Performance Indicator: Adult - Increased Stability in Housing (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Fiscal Year	FY 2006 Actual	FY 2007 Actual	FY 2008 Projected	FY 2009 Target	FY 2010 Target	FY 2011 Target
Performance Indicator	16.53	19.33	18.70	16	15	14
Numerator	1,728	1,884	--	--	--	--
Denominator	10,451	9,745	--	--	--	--

Table Descriptors:

Goal: To increase stability in housing for DMH eligible adult clients

Target: To decrease the percentage of DMH adult clients who receive case management services and are homeless by 1% each year

Population: DMH eligible adult clients receiving case management services

Criterion: 1:Comprehensive Community-Based Mental Health Service Systems
3:Children"s Services

Indicator: % of DMH adult clients receiving case management who are homeless

Measure: # of DMH adult clients receiving case management services who are homeless/# of DMH adult clients receiving case management services

Sources of Information: DMH Data Warehouse

Special Issues: In FY 2006, DMH developed a housing assessment which is completed twice a year on all DMH clients receiving case management services. This assessment includes data on housing status, history of homelessness and risk factors for homelessness. There are two caveats to this indicator. The first is that this count does not include DMH clients who are not receiving case management services who may be homeless. The second is that DMH counts clients who are currently residing in skilled nursing, rest homes and other institutional placements who do not have a permanent residence as homeless as well as those who are temporarily staying with family or friends and do not have a permanent residence. DMH recognizes that this definition of homelessness is more expansive than other states, resulting in higher than expected numbers.

Significance: DMH, through its Homeless Initiative, has placed significant emphasis on increasing housing opportunities and promoting housing stability. DMH offers a range of residential support services offered in a flexible manner to meet the individual needs of clients.

Action Plan: DMH established the housing assessment in order to better monitor and understand the housing experience of DMH clients, including those clients who are homeless or at risk for homelessness. DMH is currently conducting further analysis to identify clients who successfully achieve housing stability, remain homeless over a period of time or become newly homeless. DMH intends to utilize these additional data in informing the use of case management services and other services. DMH continues to engage in significant work with the provider community and other state agencies to promote housing supply development efforts, offer residential support services and promote housing stability.

ADULT - GOALS TARGETS AND ACTION PLANS

Transformation Activities: ☑

Name of Performance Indicator: Adult - Increased Social Supports/Social Connectedness (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Fiscal Year	FY 2006 Actual	FY 2007 Actual	FY 2008 Projected	FY 2009 Target	FY 2010 Target	FY 2011 Target
Performance Indicator	75.88	72.43	73	74	75	76
Numerator	129	155	--	--	--	--
Denominator	170	214	--	--	--	--

Table Descriptors:

Goal: Increase social connectedness of DMH eligible adult clients

Target: To be determined (please refer to Action Plan below)

Population: DMH eligible adult clients receiving case management services

Criterion: 1:Comprehensive Community-Based Mental Health Service Systems
3:Children"s Services

Indicator: % of DMH clients receiving case management services who report positively regarding social connectedness on the annual consumer and family member satisfaction survey

Measure: # of DMH clients receiving case management services reporting positively regarding social connectedness on the annual consumer and family member satisfaction survey/# of DMH clients receiving case management services who completed the social connectedness section of the annual consumer and family member satisfaction survey

Sources of Information: Annual Consumer and Family Member Satisfacation Survey

Special Issues: In 2006, DMH initiated an annual statewide Consumer and Family Member Satisfaction Survey. DMH contracted with the Center for Mental Health Services Research (CMHSR) at the University of Massachusetts to conduct this survey. Utilizing the MHSIP Consumer Survey tool, a random sample of DMH clients and family members are stratified by program type each year. Adults receiving case management services and family members of children/adolescents receiving case management services are included in the survey each year in order to maintain a consistent population for establishing benchmarks and targets. Therefore, it is important to note that while the survey samples several program types, only adults receiving case management services are included in the denominator of this goal.

Significance: DMH recognizes that an individual's involvement with natural social supports and activites is an integral component of recovery and wellness. In reviewing data from 2006 and 2007, it is noteworthy that clients demonstrated less satisfaction with social connectedness than other domains of the survey.

Action Plan: DMH is currently conducting its third annual Consumer and Family Member Satisfaction Survey. A DMH advisory group is working with CMHSR to further refine the survey methodology, improve response rates to provide valid data to meet reporting requirements, and inform program management and quality improvement efforts. In 2008, meetings were held with Central Office and Area leadership to identify areas for further data analysis and to identify opportunities for Area and statewide improvement. Social connectedness was also identified as a consumer outcome in the Quality Framework developed by the DMH Quality Council. In particular, DMH is interested in the effect increased availability of peer directed supports and services will have on this indicator.

ADULT - GOALS TARGETS AND ACTION PLANS

Transformation Activities: ☐

Name of Performance Indicator: Adult - Improved Level of Functioning (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Fiscal Year	FY 2006 Actual	FY 2007 Actual	FY 2008 Projected	FY 2009 Target	FY 2010 Target	FY 2011 Target
Performance Indicator	72.19	81.77	73	74	75	76
Numerator	122	166	--	--	--	--
Denominator	169	203	--	--	--	--

Table Descriptors:

Goal: To improve level of functioning of DMH eligible clients

Target: To increase the percentage of DMH adult clients receiving case management services who report improved level of functioning on the annual consumer and family member satisfaction survey by 1% each year

Population: DMH eligible adult clients receiving case management services

Criterion: 1:Comprehensive Community-Based Mental Health Service Systems
3:Children"s Services
4:Targeted Services to Rural and Homeless Populations

Indicator: % of DMH adult clients receiving case management services who report an improvement in functioning on the annual consumer and family member satisfaction survey

Measure: # of DMH adult clients receiving case management services who report an improvement in functioning on the annual consumer and family member satisfaction survey / # of DMH adult clients receiving case management services who completed the level of functioning section of the annual consumer and family member satisfaction survey

Sources of Information: Annual Consumer and Family Member Satisfaction Survey

Special Issues: In 2006, DMH initiated an annual statewide Consumer and Family Member Satisfaction Survey. DMH contracted with the Center for Mental Health Services Research (CMHSR) at the University of Massachusetts to conduct this survey. Utilizing the MHSIP Consumer Survey tool, a random sample of DMH clients and family members are stratified by program type each year. Adults receiving case management services and family members of children/adolescents receiving case management services are included in the survey each year in order to maintain a consistent population for establishing benchmarks and targets. Therefore, it is important to note that while the survey samples several program types, only adults receiving case management services are included in the denominator of this goal. Previously, DMH had reported on client functioning through the Current Evaluation of Risk and Functioning-Revised - a DMH-designed assessment instrument. The CERF-R continues to be used for clients receiving case management in the community as well as during inpatient state hospital admissions.

Significance: DMH initiated an annual statewide consumer satisfaction survey in 2006 in order to meet federal reporting requirements and to provide data for program management and quality improvement purposes. DMH recognizes the importance of this survey in providing valuable information on the experience and outcomes of individuals who receive services provided by DMH. DMH is particularly interested in understanding the impact of services on the outcomes and level of functioning of individuals served.

Action Plan: DMH is currently conducting its third annual Consumer Satisfaction Survey. A DMH advisory

group is working with CMHSR to further refine the survey methodology, improve response rates and provide valid data to meet reporting requirements, and inform program management and quality improvement efforts. DMH will begin to establish benchmarks and to identify emerging trends and targets once the 2007 survey data are available, providing DMH with two years of survey results.

ADULT - GOALS TARGETS AND ACTION PLANS

Transformation Activities: ☐

Name of Performance Indicator: Case Management

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Fiscal Year	FY 2006 Actual	FY 2007 Actual	FY 2008 Projected	FY 2009 Target	FY 2010 Target	FY 2011 Target
Performance Indicator	57.40	54	54.70	57	57	57
Numerator	10,451	10,708	--	--	--	--
Denominator	18,193	19,803	--	--	--	--

Table Descriptors:

Goal: Maintain case management services for DMH eligible adult clients

Target: To provide case management services to 57% of DMH eligible adult clients

Population: DMH eligible adult clients

Criterion: 1:Comprehensive Community-Based Mental Health Service Systems

Indicator: % of DMH adult clients receiving case management services

Measure: # of DMH adult clients receiving case management services/# of DMH adult clients

Sources of Information: DMH Data Warehouse

Special Issues: The denominator does not include DMH adult clients receiving PACT services.

Significance: DMH regulations require that each eligible client be assigned a DMH case manager, although DMH does not have the resources to assign a case manager to each client. While this indicator accurately reflects the number of clients receiving state-operated case management, it does not reflect the total number of clients receiving some form of care coordination at the progam level.

Action Plan: DMH continues to make every effort to retain a stable number of case managers and is committed to at least maintaining the percentage of clients receiving case management services at the current level.

ADULT - GOALS TARGETS AND ACTION PLANS

Transformation Activities: ☑☐

Name of Performance Indicator: Continuing Care Inpatient Admissions

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Fiscal Year	FY 2006 Actual	FY 2007 Actual	FY 2008 Projected	FY 2009 Target	FY 2010 Target	FY 2011 Target
Performance Indicator	66.60	70.10	62.32	66	65	64
Numerator	389	367	--	--	--	--
Denominator	584	517	--	--	--	--

Table Descriptors:

Goal: To maintain appropriate access to DMH continuing care inpatient facilities while increasing the percentage of non-forensic referrals who are appropriately diverted to community settings

Target: To decrease the percentage of non-forensic referrals to DMH continuing care who are admitted to 64% by FY 2011

Population: Non-forensic referrals to DMH continuing care inpatient facilities.

Criterion: 1:Comprehensive Community-Based Mental Health Service Systems

Indicator: % of non-forensic referrals to DMH continuing care inpatient facilities who are admitted

Measure: # of non-forensic referrals to DMH continuing care inpatient facilities who are admitted / # of non-forensic referrals to DMH continuing care inpatient facilities

Sources of Information: DMH Admissions Referral Tracking System

Special Issues: Admission to DMH continuing care inpatient facilities is based on published, uniform clinical criteria and available beds. Referrals are accepted from all acute-care hospitals as well as from the courts, however admission for all forensic (court-ordered) patients is mandatory.

Significance: When indicated, DMH staff (e.g., case managers, PACT team, housing specialists), work intensively with non-forensic patients from the referring acute-care hospital to find an appropriate alternative to hospital level of care. This may include return to a residence or to family, with necessary support, crisis step-down or community respite care. The goal is to appropriately redirect as many patients as possible to community settings, while providing access to the DMH continuing care inpatient facilities to those who need hospital level of care. This goal is consistent with the value of serving individuals in the least restrictive and most natural community setting possible. Combined with the Continuing Care Inpatient Diversion indicator, DMH expects to demonstrate that people are either appropriately admitted to or diverted from continuing care inpatient facilities.

Action Plan: In FY 2007, DMH instituted the DMH Admissions Referral Tracking System (DART). This web-based data entry system and reports module is designed to capture relevant information about all referrals to DMH continuing care units in real time, provide standardized reports and eliminate multiple and duplicative requests for information. As DMH continues to strengthen its community system through resource allocation and program development, it is expected that more individuals will be appropriately served in community, rather than inpatient, settings.

ADULT - GOALS TARGETS AND ACTION PLANS

Transformation Activities: ☑☐

Name of Performance Indicator: Continuing Care Inpatient Diversions

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Fiscal Year	FY 2006 Actual	FY 2007 Actual	FY 2008 Projected	FY 2009 Target	FY 2010 Target	FY 2011 Target
Performance Indicator	18.30	29.01	32.60	30	31	32
Numerator	107	150	--	--	--	--
Denominator	584	517	--	--	--	--

Table Descriptors:

Goal: To maintain appropriate access to DMH continuing care inpatient facilities while increasing the percentage of non-forensic referrals who are appropriately diverted to community settings

Target: To increase the appropriate diversion of admissions to DMH continuing care inpatient facilities to 32% by FY 2011

Population: Non-forensic referrals to DMH continuing care inpatient facilities

Criterion: 1:Comprehensive Community-Based Mental Health Service Systems

Indicator: % of non-forensic referrals to DMH continuing care inpatient facilities who are diverted

Measure: # of non-forensic referrals to DMH continuing care facilities who are diverted / # of non-forensic referrals to DMH continuing care facilities

Sources of Information: DMH Admissions Referral Tracking System

Special Issues: Admission to DMH continuing care inpatient facilities is based on published, uniform clinical criteria and available beds. Referrals are accepted from all acute-care hospitals as well as from the courts, however admission for all forensic (court-ordered) patients is mandatory.

Significance: When indicated, DMH staff (e.g., case managers, PACT team, housing specialists), work intensively with non-forensic patients from the referring acute-care hospital to find an appropriate alternative to hospital level of care. This may include return to a residence or to family, with necessary support, crisis step-down or community respite care. The goal is to appropriately redirect as many patients as possible to community settings, while providing access to the DMH continuing care inpatient facilities to those who need hospital level of care. This goal is consistent with the value of serving individuals in the least restrictive and most natural community setting possible. Combined with the Continuing Care Inpatient Admission indicator, DMH expects to demonstrate that people are either appropriately admitted to or diverted from continuing care inpatient facilities.

Action Plan: In FY 2007, DMH instituted the DMH Admissions Referral Tracking System (DART). This web-based data entry system and reports module is designed to capture relevant information about all referrals to DMH continuing care units in real time, provide standardized reports and eliminate multiple and duplicative requests for information. As DMH continues to strengthen its community system through resource allocation and program development, it is expected that more individuals will be appropriately served in community, rather than inpatient, settings.

ADULT - GOALS TARGETS AND ACTION PLANS

Transformation Activities: ☑☐

Name of Performance Indicator: Cultural Competence

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Fiscal Year	FY 2006 Actual	FY 2007 Actual	FY 2008 Projected	FY 2009 Target	FY 2010 Target	FY 2011 Target
Performance Indicator	73.80	84	78	79	80	81
Numerator	127	163	--	--	--	--
Denominator	172	194	--	--	--	--

Table Descriptors:

Goal: To provide culturally competent care to DMH eligible clients

Target: To increase the percentage of DMH adult clients receiving case management services who report that staff were sensitive to their cultural background on the annual consumer and family member satisfaction survey by 1% each year

Population: DMH eligible adult clients receiving case management services

Criterion: 1:Comprehensive Community-Based Mental Health Service Systems

Indicator: % of DMH adult clients receiving case management services who report that staff were sensitive to their cultural background on the annual consumer and family member satisfaction survey

Measure: # of DMH adult clients receiving case management services who report that staff were sensitive to their cultural background on the annual consumer and family member satisfaction survey/# of DMH adult clients receiving case management services who responded to the question regarding staff sensitivity to their cultural background on the annual consumer and family member satisfaction survey

Sources of Information: Annual Consumer and Family Member Satisfaction Survey

Special Issues: In 2006, DMH initiated an annual statewide Consumer and Family Member Satisfaction Survey. DMH contracted with the Center for Mental Health Services Research (CMHSR) at the University of Massachusetts to conduct this survey. Utilizing the MHSIP Consumer Survey tool, a random sample of DMH clients and family members are stratified by program type each year. Adults receiving case management services and family members of children/adolescents receiving case management services are included in the survey each year in order to maintain a consistent population for establishing benchmarks and targets. Therefore, it is important to note that while the survey samples several program types, only adults receiving case management services are included in the denominator of this goal.

Significance: DMH initiated an annual statewide consumer and family member satisfaction survey in 2006 in order to meet federal reporting requirements and to provide data for program management and quality improvement purposes. DMH is interested in analyzing the data from the consumer and family member satisfaction survey regarding issues of race, ethnicity and cultural sensitivity in order to improve provision of culturally competent care.

Action Plan: DMH is currently conducting its third annual Consumer and Family Member Satisfaction

Survey. A DMH advisory group is working with CMHSR to further refine the survey methodology, improve response rates to provide valid data to meet reporting requirements, and inform program management and quality improvement efforts. The advisory group made several improvements to the survey in 2008 to improve the response rate and appropriateness of the survey for cultural and linguistic minorities. One improvement is the use of interpreters and translated surveys and materials for DMH clients with a preferred language other than English, including the use of ASL interpreters. The survey and related materials were translated into 10 languages in 2008. In addition, several questions were added to the survey regarding the availability of translated materials and interpreters in service delivery. In 2008, meetings were held with Central Office and Area leadership to identify areas for further data analysis and to identify opportunities for Area and statewide improvement.

ADULT - GOALS TARGETS AND ACTION PLANS

Transformation Activities: ☑☐

Name of Performance Indicator: Eligibility Determination Process

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Fiscal Year	FY 2006 Actual	FY 2007 Actual	FY 2008 Projected	FY 2009 Target	FY 2010 Target	FY 2011 Target
Performance Indicator	23.90	92.18	91.10	92	93	94
Numerator	1,062	2,780	--	--	--	--
Denominator	4,438	3,016	--	--	--	--

Table Descriptors:

Goal: Facilitate access to DMH services, by improving the DMH application process for eligibility determination.

Target: To increase the percentage of individuals who complete the DMH application process for eligibility determination by 1% each year

Population: Individuals (ages 19 and above) who initiate the DMH application process for eligibility determination

Criterion: 2:Mental Health System Data Epidemiology

Indicator: % of individuals who complete the DMH application process for eligibility determination

Measure: # of individuals who complete the DMH application process for eligibility determination and for whom determination is made/# of individuals who initiate the DMH application process for eligibility determination

Sources of Information: DMH Data Warehouse

Special Issues: In 2007, DMH reviewed data on the application process for eligibility determination. This review found regional variability in the percentage of individuals found eligible, the turnaround time between application receipt and decision, and the percentage of individuals who were not determined eligible because their applications were either withdrawn or not fully initiated.

Significance: DMH realizes the NFC goals that Referral to Services is Common Practice and Mental Health Care is Consumer and Family Driven and therefore is taking steps to remove barriers to accessing services.

Action Plan: As a result of this finding, DMH instituted several changes to the eligibility process. These changes are designed to streamline paperwork, link consumers and family members with appropriate services in a more efficient manner and to provide consumers and family members with a user-friendly process that focuses on their desired outcomes and goals. Since these changes have been instituted there appears to be a significant improvement. However, DMH continues to conduct data integrity checks to evaluate the quality of these data.

ADULT - GOALS TARGETS AND ACTION PLANS

Transformation Activities: ☑☐

Name of Performance Indicator: Employment - Transition Age Youth

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Fiscal Year	FY 2006 Actual	FY 2007 Actual	FY 2008 Projected	FY 2009 Target	FY 2010 Target	FY 2011 Target
Performance Indicator	N/A	11	9.60	10	11	12
Numerator	N/A	249	--	--	--	--
Denominator	N/A	2,263	--	--	--	--

Table Descriptors:

Goal: Increase the percentage of DMH transition age youth clients (age 16-25) receiving case management services who are employed

Target: The percentage of DMH transition age youth clients (ages 16-25) receiving case management services who are employed will increase by 1% each fiscal year

Population: DMH eligible transition age youth (age 16-25) receiving case management services

Criterion: 1:Comprehensive Community-Based Mental Health Service Systems

Indicator: % of DMH transition age youth clients (age 16-25) receiving case management services who are employed

Measure: # of DMH transition age youth clients (age 16-25) receiving case management services who are employed/# of DMH transition age youth clients (16-25) receiving case management services

Sources of Information: DMH Data Warehouse

Special Issues: Currently, the DMH Mental Health Information System (MHIS) captures data on employment for DMH clients receiving case management services only. Therefore, this indicator underrepresents the true number of DMH transition age youth clients who are employed because it does not provide a count of individuals who are enrolled in all DMH-funded employment programs or who may be working. Employment for this indicator is defined as part-time, full-time, supported or self employment. The Employment sub-committee of the Planning Council advocates for the inclusion of volunteer work in this definition, however the data reported in this indicator are consistent with the federal definition. Data are not collected within MHIS on job tenure. Employment data for FY 2006 are not available. Employment data for DMH eligible adult clients (age 26 and over) receiving case management services are reported as a separate performance indicator.

Significance: DMH recognizes employment as an important component of recovery as well as a means of achieving self sufficiency. Employment is of particular concern for the transition age youth population as DMH is developing specialized services to meet their unique needs. Employment services are offered through several DMH funded programs, including clubhouses, Services for Education and Employment, and Program of Assertive Community Treatment. In addition to DMH's focus on employment, the Employment sub-committee and the Youth Development Committee of the Planning Council have been advocating for increased access to employment support services.

Action Plan: DMH plans to develop an Employment Assessment within MHIS to collect additional data on employment. This employment indicator will also be added to the DMH Community Indicator Report. This monthly report is currently being developed and will serve as a program management and quality improvement tool for DMH managers. DMH continues to engage in significant planning which is intended to increase and improve the services provided to transition age youth, including employment services.

ADULT - GOALS TARGETS AND ACTION PLANS

Transformation Activities: ☑☐

Name of Performance Indicator: PACT - # of Hospital Days

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Fiscal Year	FY 2006 Actual	FY 2007 Actual	FY 2008 Projected	FY 2009 Target	FY 2010 Target	FY 2011 Target
Performance Indicator	19.44	20.10	18.10	17	16	15
Numerator	13,027	14,283	--	--	--	--
Denominator	670	710	--	--	--	--

Table Descriptors:

Goal: To increase the percentage of adults served by a PACT team who remain in the community

Target: To decrease the # of days of psychiatric hospitalization per client / per year by 1 day each fiscal year

Population: DMH eligible adult clients served by a PACT team

Criterion: 1:Comprehensive Community-Based Mental Health Service Systems

Indicator: # of days of psychiatric hospitalization per client for the fiscal year

Measure: # of days of psychiatric hospitalization for all clients served by PACT in the fiscal year / # of clients served by PACT in the fiscal year

Sources of Information: Performance Based Contracting

Special Issues: In FY 2006 and 2007, the data accounted for five of the six DMH Areas as the sixth Area included individuals who spent much or most of the year as inpatients and received no PACT services but remained technically enrolled in PACT teams.

Significance: For those clients in the community whose multiple problems, including homelessness and non-adherence, may require up to 24-hour intensive oversight to support their functioning, including help with housing and employment, and avoiding the need for psychiatric hospitalization, DMH, with MassHealth assistance, created 15 PACT teams statewide. Among other goals, the PACT teams aim to reduce the need for psychiatric hospitalization.

Action Plan: DMH expects to improve the outcomes of DMH clients receiving PACT services, including improving community tenure, through ongoing supervision, consultation, training and fidelity assessments. In FY 2008, PACT MDs met to discuss their referral and hospitalization procedures. In addition, the PACT consultant is currently reviewing the acuity and crisis planning standards and working with PACT teams to ensure consistent implementation.

ADULT - GOALS TARGETS AND ACTION PLANS

Transformation Activities: ☑☐

Name of Performance Indicator: PACT - Employment

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Fiscal Year	FY 2006 Actual	FY 2007 Actual	FY 2008 Projected	FY 2009 Target	FY 2010 Target	FY 2011 Target
Performance Indicator	14.10	15.28	15.90	15	16	17
Numerator	111	127	--	--	--	--
Denominator	788	831	--	--	--	--

Table Descriptors:

Goal: To increase the percent of PACT clients who are employed

Target: To increase the percent of PACT clients who are employed by 1% each fiscal year

Population: DMH eligible adult clients served by PACT teams

Criterion: 1:Comprehensive Community-Based Mental Health Service Systems

Indicator: % of adults served by PACT teams who are employed

Measure: # of adults served by PACT teams who are employed / # of adults served by PACT teams

Sources of Information: Performance Based Contracting

Special Issues: None

Significance: For those clients in the community whose multiple problems, including homelessness and non-compliance, may require up to 24-hour intensive oversight to support their functioning, including help with housing and employment, and avoiding the need for psychiatric hospitalization, DMH, with MassHealth assistance, created 15 PACT teams statewide. Among other goals, the PACT teams aim to increase employment of PACT clients.

Action Plan: DMH expects to improve the outcomes of DMH clients receiving PACT services, including increasing employment of PACT clients, through ongoing supervision, consultation, training and fidelity assessments. During FY 2008, two trainings were offered to PACT teams on employment as an outcome and the use of evidence-based practices in promoting employment. In addition, the PACT coordinator and consultant met with PACT team leaders and employment specialists to review expectations around employment activities and requested that each team work with its Area/Site to set goals for time spent in job development and percent of clients employed.

ADULT - GOALS TARGETS AND ACTION PLANS

Transformation Activities: ☑☐

Name of Performance Indicator: PACT - Receiving Substance Abuse Treatment

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Fiscal Year	FY 2006 Actual	FY 2007 Actual	FY 2008 Projected	FY 2009 Target	FY 2010 Target	FY 2011 Target
Performance Indicator	91	86	87.60	88	89	90
Numerator	292	315	--	--	--	--
Denominator	321	366	--	--	--	--

Table Descriptors:

Goal: To increase the percentage of adults served by PACT teams who need and receive substance abuse services

Target: To increase the percentage of adults served by PACT teams who need and receive substance abuse services by 1% each year

Population: DMH eligible adult clients served by PACT teams

Criterion: 1:Comprehensive Community-Based Mental Health Service Systems

Indicator: % of adults served by PACT teams who need and receive substance abuse services

Measure: # of adults served by PACT teams who need and receive substance abuse services / # of adults served by PACT teams who need substance abuse treatment

Sources of Information: Performance Based Contracting

Special Issues: None

Significance: For those clients in the community whose multiple problems, including homelessness and non-compliance, may require up to 24-hour intensive oversight to support their functioning, including help with housing and employment, and avoiding the need for psychiatric hospitalization, DMH, with MassHealth assistance, created 15 PACT teams statewide. Among other goals, the PACT teams aim to ensure that clients receive treatment for substance abuse if indicated.

Action Plan: DMH expects to improve the outcomes of DMH clients receiving PACT services, including ensuring that clients receive substance abuse treatment if indicated, through ongoing supervision, consultation, training and fidelity assessments. In FY2008, Substance Abuse Specialists met to begin work on the development of an improved assessment tool.

ADULT - GOALS TARGETS AND ACTION PLANS

Transformation Activities: ☑☐

Name of Performance Indicator: PACT - Stability in Housing

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Fiscal Year	FY 2006 Actual	FY 2007 Actual	FY 2008 Projected	FY 2009 Target	FY 2010 Target	FY 2011 Target
Performance Indicator	90.70	85.92	84.10	85	86	87
Numerator	715	714	--	--	--	--
Denominator	788	831	--	--	--	--

Table Descriptors:

Goal: To increase the percentage of adults served by PACT teams who are maintained in community housing

Target: To increase the percentage of adults served by PACT teams who are maintained in community housing by 1% each fiscal year

Population: DMH eligible adult clients served by PACT teams

Criterion: 1:Comprehensive Community-Based Mental Health Service Systems

Indicator: % of adults served by PACT teams who are maintained in community housing

Measure: # of adults served by PACT teams who are maintained in community housing / # of adults served by PACT teams

Sources of Information: Performance Based Contracting

Special Issues: None

Significance: For those clients in the community whose multiple problems, including homelessness and non-compliance, may require up to 24-hour intensive oversight to support their functioning, including help with housing and employment, and avoiding the need for psychiatric hospitalization, DMH, with MassHealth assistance, created 15 PACT teams statewide. Among other goals, the PACT teams aim to maintain clients in community housing.

Action Plan: DMH expects to improve the outcomes of DMH clients receiving PACT services, including maintaining clients in community housing, through ongoing supervision, consultation, training and fidelity assessments. In FY2008, a training on housing subsidies and avenues of recourse to obtain housing and prevent eviction was offered to PACT teams.

ADULT - GOALS TARGETS AND ACTION PLANS

Transformation Activities: ☐

Name of Performance Indicator: Participation in Treatment Planning

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Fiscal Year	FY 2006 Actual	FY 2007 Actual	FY 2008 Projected	FY 2009 Target	FY 2010 Target	FY 2011 Target
Performance Indicator	63	64	64	65	66	67
Numerator	102	136	--	--	--	--
Denominator	162	212	--	--	--	--

Table Descriptors:

Goal: To improve the process for involving clients in treatment planning

Target: To increase the percentage of DMH adult clients receiving case management services who report positively about their involvement in treatment planning on the annual consumer and family member satisfaction survey by 1% each year

Population: DMH eligible adult clients receiving case management services

Criterion: 1:Comprehensive Community-Based Mental Health Service Systems

Indicator: % of DMH adult clients receiving case management services who report positively regarding participation in treatment planning on the annual consumer and family member satisfaction survey

Measure: # of DMH adult clients receiving case management services who report positively regarding participation in treatment planning on the annual consumer and family member satisfaction survey / # of DMH adult clients receiving case management services who complete the participation in treatment planning section of the annual consumer and family member satisfaction survey

Sources of Information: Annual Consumer and Family Member Satisfaction Survey

Special Issues: In 2006, DMH initiated an annual statewide Consumer and Family Member Satisfaction Survey. DMH contracted with the Center for Mental Health Services Research (CMHSR) at the University of Massachusetts to conduct this survey. Utilizing the MHSIP Consumer Survey tool, a random sample of DMH clients and family members are stratified by program type each year. Adults receiving case management services and family members of children/adolescents receiving case management services are included in the survey each year in order to maintain a consistent population for establishing benchmarks and targets. Therefore, it is important to note that while the survey samples several program types, only adults receiving case management services are included in the denominator of this goal.

Significance: DMH initiated an annual statewide consumer and family member satisfaction survey in 2006 in order to meet federal reporting requirements and to provide data for program management and quality improvement purposes. In reviewing the data from the 2006 and 2007 surveys, it was noted that clients demonstrated less satisfaction with participation in treatment planning than with other domains in the survey.

Action Plan: DMH is currently conducting its third annual Consumer and Family Member Satisfaction Survey. A DMH advisory group is working with CMHSR to further refine the survey methodology, improve response rates to provide valid data to meet reporting requirements, and inform program management and quality improvement efforts. In 2008, meetings were held with Central Office and Area leadership to identify areas for further data analysis and to identify opportunities for Area and statewide improvement.

ADULT - GOALS TARGETS AND ACTION PLANS

Transformation Activities: ☑☐

Name of Performance Indicator: Peer Support

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Fiscal Year	FY 2006 Actual	FY 2007 Actual	FY 2008 Projected	FY 2009 Target	FY 2010 Target	FY 2011 Target
Performance Indicator	N/A	47	48	45	49	54
Numerator	N/A	N/A	--	--	--	--
Denominator	N/A	N/A	--	--	--	--

Table Descriptors:

Goal: To increase the availability of peer support services

Target: To train and certify 45 Certified Peer Specialists (CPS) in FY 2009; 49 in FY 2010; and 54 in FY 2011

Population: Certified Peer Specialists

Criterion: 1:Comprehensive Community-Based Mental Health Service Systems

Indicator: # of individuals who have completed training and received certification as a Certified Peer Specialist

Measure: # of individuals who have completed training and received certification as a Certified Peer Specialist

Sources of Information: Transformation Center

Special Issues: The Transformation Center (TC) worked with Larry Fricks and Ike Powell of the Appalachia Consulting Group to adapt and implement the Certified Peer Specialist Training in Massachusetts. The program was modeled after Georgia?s successful program and is an eight-day residential experience. The TC developed a strong in-state training team and held seven trainings in the past two years. Data for 2006 are not available as this training initiative began in FY 2007.

Significance: There are currently over 95 Certified Peer Specialists in Massachusetts. In June 2008, the second annual ceremony honoring Peer Specialists was held at the State House to highlight the success of this program to legislators and other community leaders. It is expected that Certified Peer Specialists will function as agents of change in the transformation of the mental health system.

Action Plan: DMH continues to work closely with the Transformation Center to provide Certified Peer Specialist training. In addition, DMH, the Transformation Center and TransCom - a steering committee of the Systems Transformation grant, are collaborating to expand employment opportunities for Certified Peer Specialists, integrating this new role into the current system and supporting this role as a transformative agent.

ADULT - GOALS TARGETS AND ACTION PLANS

Transformation Activities: ☐

Name of Performance Indicator: Residential Services

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Fiscal Year	FY 2006 Actual	FY 2007 Actual	FY 2008 Projected	FY 2009 Target	FY 2010 Target	FY 2011 Target
Performance Indicator	94.30	94.14	94.60	93	93	93
Numerator	8,268	7,514	--	--	--	--
Denominator	8,772	7,959	--	--	--	--

Table Descriptors:

Goal: Maintain the number of adults living in the community with residential support services

Target: 93% of DMH adult clients determined to need residential support services will receive residential support services each fiscal year

Population: DMH eligible adult clients determined to need residential support services

Criterion: 1:Comprehensive Community-Based Mental Health Service Systems

Indicator: % of DMH adult clients determined to need residential support services who received residential support services

Measure: # of DMH adult clients determined to need residential support services who received residential support services/# of DMH eligible adult clients determined to need residential support services

Sources of Information: DMH Data Warehouse

Special Issues: The numerator represents an unduplicated number of adults (including elders) receiving residential services (both contracted and state-run). The denominator represents those consumers who are receiving these services as well as those who have requested and are eligible for them (waitlist). It should be noted that residential support services, as quantified by this indicator, include only residential services that are coded as such by DMH and paid directly from one specific account. A range of other services that place, support and/or assist to maintain individuals in a stable housing situation, but which are not explicitly labeled as "residential" are not included in this count. These include DMH housing vouchers, case management and services provided through clubhouses and community rehabilitative support contracts. Therefore, the indicator under-represents the amount of effort dedicated to maintaining individuals in housing.

Significance: DMH is commited to providing residential services to DMH clients who need them.

Action Plan: DMH regularly assesses the accuracy of the waitlist in order to ascertain the real need for residential support services for DMH clients. This service is currently being reviewed as part of the current community-based services reprocurement process as noted in the Executive Summary. DMH is currently soliciting feedback through a Request for Information.

ADULT - GOALS TARGETS AND ACTION PLANS

Transformation Activities: ☑☐

Name of Performance Indicator: Restraint Reduction

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Fiscal Year	FY 2006 Actual	FY 2007 Actual	FY 2008 Projected	FY 2009 Target	FY 2010 Target	FY 2011 Target
Performance Indicator	8.37	5.86	5.16	4.10	3.90	3.80
Numerator	N/A	N/A	--	--	--	--
Denominator	N/A	N/A	--	--	--	--

Table Descriptors:

Goal: To reduce the incidents of restraint in DMH inpatient facilities

Target: The number of reported incidents of restraint (per 1,000 patient days) will decrease to no more than 4.1 in FY 2009; 3.9 in FY 2010; and 3.8 in FY 2011.

Population: Adults admitted to DMH inpatient facilities

Criterion: 1:Comprehensive Community-Based Mental Health Service Systems

Indicator: # of reported incidents of restraint in DMH inpatient facilities per 1,000 patient days

Measure: # of reported incidents of restraint in DMH inpatient facilities per 1,000 patient days

Sources of Information: Statewide Restraint and Seclusion Reporting System

Special Issues: DMH collects monthly statewide restraint and seclusion data from all licensed, state-operated and state-contracted inpatient units and facilities. However, this indicator only includes data from state-operated inpatient facilities.

Significance: In October 2004, Massachusetts was one of eight states to receive a State Incentive Grant (SIG) funded by SAMHSA through the National Association of State Mental Health Program Directors, (NASMHPD). This three-year grant to DMH was specifically designed to assist in the development and implementation of a restraint and seclusion reduction/elimination initiative in DMH-operated facilities.

Action Plan: DMH has since implemented a system-wide initiative to reduce and eliminate the use of seclusion and restraint in its state-operated facilities. All ten state hospitals and community mental health centers adopted the Six Core Strategies? developed by the National Technical Assistance Center (NTAC) of NASMHPD. A one-day Culture Change conference is planned for September 4, 2008 which will create the opportunity for DMH and individual facilities to continue to map out a plan for moving toward a more recovery and resiliency based system through collaborative partnerships. DMH is also planning for sustainability of the grant activities.

Massachusetts

Child - Establishment of System of Care

Child - Provides for the establishment and implementation of
an organized community-based system of care for individuals with mental illness.

Criterion I: Comprehensive Community-Based Mental Health Services

Establishment of System of Care

Massachusetts has provided community-based care since 1966, when the legislature created the structure for an area-based system. Until 1991, however, a disproportionate share of DMH's resources was tied up in the state's antiquated psychiatric hospitals. Since that time, five hospitals have been closed (four adult and the only state-operated children's hospital) and savings have been reinvested in community programs and infrastructure, clients and other stakeholders have increased their participation in planning and policy development, and area-based management has been anchored by statewide standards. These changes have created an enhanced and vigorous community-based system of care for adults, children and adolescents.

Based upon statewide program service definitions and program quality standards, each of the six DMH Areas assesses its needs, and develops and manages its services, mostly through contracts with local providers. Only forensic mental health services and the statewide extended-stay inpatient and intensive residential treatment programs for children and adolescents are managed centrally, including two Behaviorally Intensive Residential Treatment programs that DMH developed for youth in the care or custody of the Department of Children and Families (formerly known as the Department of Social Services).

Massachusetts

Child - Available Services

Child - Describes available services and resources in a comprehensive system of care, including services for individuals with both mental illness and substance abuse. The description of the services in the comprehensive system of care to be provided with Federal, State, and other public and private resources to enable such individuals to function outside of inpatient or residential institutions to the maximum extent of their capabilities shall include:

Health, mental health, and rehabilitation services;
Employment services;
Housing
services;
Educational services;
Substance
abuse services;
Medical and dental services;
Support services;
Services provided by local school
systems under the Individuals with Disabilities Education Act;
Case management services;
Services
for persons with co-occurring (substance abuse/mental health) disorders; and
Other activities
leading to reduction of hospitalization.

Criterion 1: Comprehensive Community-Based Mental Health Services

Available Services

DMH directly provides and/or funds a range of direct services for approximately 2,834 children and adolescents ages 0 to 19 per year who have serious emotional disturbance. This figure represents annual service enrollment and does not include youth receiving emergency services, youth receiving evaluations through court clinics, or youth served through interagency projects to which DMH contributes funds but for which it is not the program administrator. In addition, this figure does not include the approximately 4,000 youth who receive indirect services through school and community support programs, such as training and consultation to schools. Publicly funded acute-care services, including inpatient, emergency and outpatient as well as some family stabilization and case management services are managed by Mass Health.

Health and Mental Health Services

Health, acute-care mental health services, and some intermediate care services for youth who are DMH clients are provided through public or private insurance, with virtually all children in the state having access to some primary care coverage. Part of the responsibility of case managers and program staff is to work with parents and youth themselves to help them get connected and stay connected to appropriate mental health and other health services. Eligibility staff work with DMH applicants to assure that they are enrolled for all benefits to which they are entitled, and case managers and provider staff advocate with insurers on questions of coverage. DMH has been meeting regularly with the Division of Insurance, the Department of Public Health and HMOs to develop guidance that will further clarify the requirement of the mental health parity legislation.

At a systems level, DMH works closely with the Massachusetts Chapter of the American Academy of Pediatrics, particularly with its mental health task force. The Academy has been successful on one of its key agenda items, which was to secure agreement from the state's major HMOs to reimburse for mental health screening. DMH serves on the Steering Committee of the Consortium for Children with Special Health Care Needs to assure that the special service and case management needs of children with SED are addressed within the design of a Medical Home, where services are coordinated through the primary care physician.

Rehabilitation Services

As DMH is the primary provider/contractor of continuing care community-based services, the concepts of rehabilitation and support are at the core of its programs. However, the word resilience rather than rehabilitation is generally used for children and adolescents as the focus is on getting children on track for age-appropriate development, acquiring new skills and strategies that will enable them to grow up into highly functioning adults.

Most community-based programs provide resilience building, rehabilitative and supportive functions in a flexible manner to match the goals and needs of the individual client. These include case management, after-school day services, supported education and skills training, therapeutic foster care, individual and family flexible support,

including in-home treatment, mentoring and respite care and a range of residential services, provided in group care, apartment, or home settings. For children with severe needs, DMH has structured its contracts so that a residential level of care can be provided in a child's home if clinically appropriate. Emergency services, available to the community at large, are provided through the Mass Health contracted behavioral health vendor (MBHP), except in one DMH Area in which they are state-operated. Funded by DMH in collaboration with the Juvenile Court Department of the Trial Court, juvenile court clinics operate across the state to provide assessments and referrals for children who come before the court, and that thereby promote diversion into treatment. In addition to community based services, DMH also contracts for extended stay inpatient services for adolescents, and for secure intensive residential treatment programs.

Each person receiving DMH funded direct services has a Program Specific Treatment Plan (PSTP) specifying the service and support components that will be provided to the child and or family by that provider, and the outcomes these services are expected to achieve. If youth have a case manager, the PSTPs also become part of the Individual Service Plan (ISP), providing a level of specificity beyond what is in the PSTP.

DMH funds parent support coordinators in every DMH Area who assist other parents to navigate the system, access entitlements and develop the confidence to speak up for their child's and family's needs. Parent coordinators also facilitate parent support groups open to all parents or caregivers of a child with emotional or behavioral needs. In addition, DMH provides funding to the statewide parent organization to promote parent participation in policy and program development so that services are family-driven, from the design on.

Employment Services

The focus on transition age youth, ages 16-25, has increased the attention given to pre-vocational skill development and supported work and supported education activities. Residential providers and those providing intensive in-home interventions focus on arranging and supporting part-time work opportunities for youth that they can manage while still in school and during the summer. DMH training for case managers in understanding the requirements of IDEA in regard to transition have focused on helping them learn to use the IEP to promote vocational preparation, and also about services available through the Massachusetts Rehabilitation Commission (MRC). Parent coordinators have also been trained on these topics.

There is one adolescent only employment program. For older youth who have graduated or left school, DMH sponsors community-based programs that assist with achieving employment or educational objectives; both as a means of furthering the recovery process and promoting economic well being. DMH delivers these services to clients primarily by contracting with private vendors. The major programs of this type are the Services for Education and Employment (SEE) and Community Support Clubhouses.

- Services for Education and Employment (SEE)
  The SEE program consists of 25 local projects in communities across the state, 13 of which serve youth under the age of 19. The program strives to assist DMH

clients in securing employment; obtain work training; and/or address remedial, basic, or post secondary education needs. Clients are offered flexible, individualized supports with the goal of producing permanent employment with mainstream employers. Education and/or training placements are also offered, with the intent of better preparing clients to enter into competitive employment. The individual SEE projects engage in active job development in their communities and form relationships with employers and mainstream employment, training, and educational systems external to the mental health community.

- Community Support Clubhouses
  DMH's Community Support Clubhouses provide members with a range of career counseling, job search, training, support, and placement services for obtaining and maintaining permanent, supported, or transitional employment. Clubhouses also serve as multi-service centers for DMH clients and other persons with mental illness living in the community. In addition to the more traditional job development, training, and employment services offered, each clubhouse operates under a "work ordered day" philosophy. Clubhouses pursue a variety of jobs for members including integrated, independent employment. Although initially designed for adult clients, 6 clubhouses have significantly modified their programs to make them attractive to older adolescents.

Housing Services

Virtually all youth under the age of 18 served by DMH who are not in a residential treatment program live in the home of a family member or foster home, as do most youth who are age 18. DMH focuses on supports to youth and their families or caregivers in order to facilitate that kind of living arrangement, as is normative in our society as well as economically realistic. Most youth, however, aim to eventually live independently. DMH supports this goal in several ways. Adolescent residential providers are required to use a formal curriculum to teach independent living skills, and teaching these skills can also be a focus of intervention for those receiving community-based flexible supports. DMH currently funds a few supported housing slots specifically for older youth. As an agency, DMH has sponsored aggressive efforts to increase supported housing opportunities for its clients. DMH Central Office maintains a housing staff which works with DMH providers and state and local housing agencies to promote housing supply development efforts in support of DMH's locally administered discharge planning process and to achieve other DMH agency-wide housing and community-based treatment goals. This Central Office housing function is carried out in conjunction with Area Housing Coordinators in each of DMH's six Area Offices.

Educational Services

Children receiving community-based mental health services, including those living in residential programs, receive their educational services through their local educational authority, and are enrolled in public school programs or special education day programs either within or outside the school district. Most DMH clients receive special education services, while some receive Section 504 accommodations to address their mental health needs. In accord with state law, the state Department of Elementary and Secondary Education (ESE), through its division of Special Education Services in

Institutional Settings (SEIS) is responsible for delivery of educational services in DMH's inpatient and intensive residential programs, either directly or through provider contracts. DMH program staff work closely with the SEIS teachers assigned to them so that their work and approach with the child is complementary. Youth who have graduated or left school may receive supported education services from the SEE programs described above under Employment.

Each DMH Area funds community and school support contracts with providers to offer training and consultation to local schools and/or local school systems and thus support mainstreaming. The focus of training is usually to help school staff understand the needs of children with serious emotional disturbance, develop sensitive and effective classroom responses to children with SED, identify children at suicidal risk and implement suicide prevention strategies, respond to individual or community trauma, and facilitate referrals to mental health services. In some Areas, DMH-funded staff participate on student support teams within schools. DMH is also a co-funder and Steering Committee member of an EOHHS pilot project involving state agencies and 13 school districts and educational collaboratives to improve linkages between schools and mental health and social services.

Substance Abuse Services/Services for Persons with Co-Occurring Disorders

DMH has a long standing commitment to including those with a dual diagnosis of serious mental illness and substance abuse in its programs and services and in providing them with integrated treatment. Eight years ago, DMH incorporated program standards for the care and treatment of individuals with co-occurring disorders into its Residential Services contracts. In addition, training requirements for managing individuals with co-occurring disorders were included in the Department's SFY'04 Psychiatry Residency and Psychology Internship Training Program contract.

To increase access and the quality of services, DMH has been an active member of an Interagency Work Group (IWG) established by the Department of Public Health in 2001 that meets monthly. Membership includes the Departments of Children and Famililes, Youth Services, Mental Retardation and Transitional Assistance, MBHP, the Juvenile Court, the Parent Professional Advocacy League (PAL) and selected substance abuse providers, as well as DMH. The IWG goals are to build common understanding and vision across state systems; design and implement a community centered system of comprehensive care for youth with behavioral health disorders that incorporates evidence based practice; coordinate service delivery across systems; and simplify administrative processes and purchasing strategies that maximize federal and state dollars.

Department of Public Health and DMH share the goal of finding solutions to those issues inherent in mental health and substance abusing clients who are serviced in both systems and to identify the emerging needs and resources necessary for a successful course of treatment. The DMH sponsored training series in Motivational Interviewing which is an evidenced-based practice for dually diagnosed adolescents and young adults was over-subscribed. . Additional training is proposed for the next fiscal year.

Medical and Dental Services

Children under age 18 remain in the custody of their parents, or of the Department of Children and Families who, as the holders of legal custody, retain primary

responsibility for making sure that children receive medical and dental care. Nonetheless, there are several ways in which DMH promotes access to primary health care for those under 18 and for those who are their own guardians. The Individual Service Plan, as per the Service Planning regulations, requires evidence of an annual physical and dental exam. DMH also tracks whether clients in residential programs see their primary care physician annually. Case managers assist families and clients in enrolling in public or private insurance and accessing benefits, and by arranging for or providing transportation to needed medical or dental services. In the past year, Mass Health restored the dental benefit and made administrative adjustments to encourage pediatric dentists to become Mass Health providers, thus facilitating access to dental care for many.

Support Services

Supports to children and their families are a critical element of the continuing care community-based services and are an integral part of the rehabilitation services described above. Individual and family flexible support programs available across the state include but are not limited to provision of supports such as respite care, parent mentors, parent aides, youth mentors, therapeutic recreation, and transportation, including transportation and lodging for families whose children are placed in a hospital or treatment facility at a distance from their home.

Reflecting its strong commitment to keeping children at home, DMH has made a strong investment in supporting parent and families whose children have mental health problems. DMH supports the central administrative structure of the Parent Professional Advocacy League (PAL), funds parent coordinators in each DMH Area, and provides the funding for parent partners and flexible funds for interagency blended funding projects. Parent coordinators facilitate self-help groups and trainings for families and caregivers of children with mental health, emotional or behavioral problems, provide training on relevant topics and assist parents to advocate on behalf of their children particularly in relation to service planning, insurance coverage and special education. Parent partners work in the interagency projects as part of the care coordination team.

Services Provided by Local School Systems under the Individuals with Disabilities Education Act (IDEA)

DMH provides training for case managers on accessing services under Individuals with Disabilities Education Act and under Section 504. PAL and the parent support coordinators provide similar trainings to parents in the community. Parents receive assistance with individual educational issues. Case managers attend IEP meetings at school, or provide information to the team, as requested by the parent, and with parental approval school staff participates in Individual Service Planning meetings. An attempt is made to have the IEP and ISP meetings held at the same time and place, to assure that the plans are complementary. As noted above under Education, children in hospitals or intensive residential treatment programs have their special education services delivered through the Department of Elementary and Secondary Education in accord with the local IEP.

Local systems provide counseling within the school, usually contracting with local DMH providers for this and child specific consultation. Schools provide a variety

of interventions, including but not limited to: aides; resource rooms; substantially separate classrooms, within district or out of district, or operated by educational collaboratives; home tutoring; or placement in residential school. Depending on circumstances, DMH may pay for the residential component of such a placement while the school system pays for the education only component. If a child is enrolled in a DMH after-school treatment program, schools may provide transportation to the program.

The state director of special education participates on almost all interagency planning activities related to children's mental health and the Department of Elementary and Secondary Education (ESE) has been a payer in interagency blended funding initiatives.

Case Management Services

Since it developed its case management policy in 1987, DMH has acknowledged the importance of case management and individual service planning in connecting clients to needed services, but has not had sufficient resources to assign a case manager to each eligible client. Therefore, the policy established priority for state-operated case management services for those adults with serious, long-term mental illness and children with serious emotional disturbance who were being discharged from inpatient stays or with a history of repeated psychiatric hospitalizations, homeless with mental illness, or unable to meet life support needs of shelter, food, clothing and self-care. They also were mandated specifically for children in the statewide continuing care units. Case management was organized primarily as a "brokerage" model.

In SFY'98 and SFY'99, DMH undertook a thorough examination of the DMH case management system. This project began as DMH was revising the remaining section of its regulations on service planning (SP) and occurred at the same time that a uniform process to determine eligibility for DMH continuing care community services was being implemented. The SP project involved a task force, focus groups and extensive public input from all of DMH's stakeholders and succeeded in defining a "DMH client" in a behavioral managed mental health care environment. After significant public comment and further review, the final regulations were promulgated on July 1, 1999 with a phased-in implementation process planned. The regulations state that every individual who meets the clinical criteria, is determined to be in need of at least one existing DMH continuing care community service, and has no other means of obtaining that service will be eligible for DMH community services, including case management. Case management remains a state-operated service. Clients are assigned a case manager based on the intensity of their need and as resources permit. A process has been developed to triage clients to determine their priority of need. It is not necessary to have a case manager in order to access DMH continuing care services or parent support services. Case manager supervisors often provide short term case management to address urgent issues.

Services for Persons with Co-Occurring disorders

See above under Substance Abuse

Reducing the Rate of Hospitalization

DMH has continued to work hard to shift its focus to community-based care. Since 1992, DMH has closed five state hospitals, including the state-operated children's center, transferring responsibility for acute care from the public to the private sector. Children and adolescents receive acute inpatient care in private or general hospitals. This has enabled DMH to focus its expertise on providing continuing and rehabilitative care in the community.

The emphasis on prevention of seclusion and restraint has substantially reduced the need for continued care hospitalization as high restraint use was a key indicator of the need for ongoing hospitalization. In 2007, DMH closed one of its three continuing care adolescent units, leaving a capacity of two units with 30 beds, and redeployed the funds into diversionary services and other community supports.

Although it does not provide acute-care hospitalization, DMH continues to attend to issues related to it. In 2006, DMH became concerned with the rate at which DMH clients (adult and child/adolescent) were being readmitted to acute-care facilities. The Massachusetts Behavioral Health Partnership (MBHP) tracks readmission rates as a part of the management of its provider network. After reviewing this data, the Commissioner formed a quality improvement project with the aim of reducing 30 day readmission rates for DMH/MBHP clients to acute-care inpatient facilities. A joint partnership between DMH, the Mass Health Behavioral Health Unit and MBHP, this statewide Readmission Collaborative has 50 members representing these three organizations, consumers and providers. The Collaborative values data, shared learning and the use of rapid Plan-Do-Study-Act cycles to implement, test and spread interventions intended to reduce readmission rates.

Services for Clients with Special Needs

Deaf, Hard of Hearing and Late-deafened

DMH continues to maintain and increase its services to Deaf and Hard of Hearing clients. There are currently four Deaf or ASL fluent case managers who provide case management services across the state. Approximately 100% of DMH Deaf clients are served by a signing case manager or the signing case manager works with the non-signing case manager. Approximately 90% of clients have reliable accessibility in their treatment programs. DMH has also established procedures that require that access issues be addressed in Individual Service Plans and during the process of eligibility. Funds directed towards expanded residential, community support and vocational services have been maintained. These services are coordinated through a part-time position at Central Office. For the next FY one goal is to develop and implement a way to assess the ASL fluency of non-deaf staff that work with Deaf DMH clients who use ASL.

Court-Involved Youth

DMH has a long history of providing forensic mental health services to the juvenile justice system and to DMH facilities, including DMH contracted adolescent residential units. In SFY '99, the DMH Forensic Division assumed responsibility for procuring and managing all clinical services for the statewide Juvenile Court. Forensic specialists sited in the juvenile courts provide evaluation and consultation services for judges and probation officers on an as-needed basis, as well as treatment for children.

Since juvenile court clinics began evaluating children under age 12, detention use for this population has dropped from more than 230 a year to approximately 75 a year. Protocols between the Department of Youth Services (DYS - the juvenile justice service system) and DMH have been developed to assure timely information sharing and thoughtful transition planning for youth with mental health needs in the DYS system.

Massachusetts

Child - Estimate of Prevalence

Child - An estimate of the incidence and prevalence in the State of serious mental illness among adults and serious emotional disturbance among children

Criterion 2: Mental Health System Data Epidemiology

Estimate of Prevalence

Prevalence Estimates for Children & Adolescents (based on 2006 census-derived population estimates)

DMH Area	Total Population 0-18	Total Population 0-8	Total Population 9-18	SED 9-18 with extreme dysfunction (6%)	SED 9-18 with substantial functional impairment (10%)	SED 0-8 in need of mental health services (2.5%)
Western	**206,331**	**99,039**	**107,292**	**6,438**	**10,729**	**2,476**
Central	**210,829**	**101,198**	**109,631**	**6,578**	**10,963**	**2,530**
North East	**316,851**	**152,088**	**164,763**	**9,886**	**16,476**	**3,802**
Metro Boston	**229,692**	**110,252**	**119,440**	**7,166**	**11,944**	**2,756**
Metro Suburban	**328,079**	**157,478**	**170,601**	**10,236**	**17,060**	**3,937**
South-eastern	**317,516**	**152,408**	**165,108**	**9,906**	**16,511**	**3,810**
Total	**1,609,298**	**772,463**	**836,835**	**50,210**	**83,233**	**19,311**

The total planning population of children and adolescents in Massachusetts (the sum of the last two columns) is *102,544*.

Massachusetts

Child - Quantitative Targets

Child - Quantitative targets to be achieved in the implementation of the system of care described under Criterion 1

Criterion 2: Mental Health System Data Epidemiology

Quantitative Targets
Please refer to access indicators in the Goals, Targets and Action Plans section.

Massachusetts

Child - System of Integrated Services

Child - Provides for a system of integrated services appropriate for the multiple needs of children without expending the grant under Section 1911 for the fiscal year involved for any services under such system other than comprehensive community mental health services. Examples of integrated services include:

Social services;
Educational services, including services provided under the Individuals with Disabilities Education Act;
Juvenile justice services;
Substance abuse services; and

Health and mental health services.

Criterion 3: Children's Service

System of Integrated Services

The Executive Office of Health and Human Services (EOHHS) which encompasses Mass Health, is the responsible secretariat for the coordination of all children's services in Massachusetts. The agencies within EOHHS serving children exclusively are the Departments of Children and Families (DCF), and Youth Services (DYS). The Departments of Public Health (DPH), Mental Health (DMH), Mental Retardation (DMR), and Transitional Assistance (DTA) and the Commissions for the Blind, and Deaf and Hard-of-Hearing, serve children and adults. The Departments of Elementary and Secondary Education (ESE) and Early Education and Care (DEEC) are not within EOHHS. DMH has primary responsibility for delivery of non-acute continuing care mental health services for those children with serious emotional disturbance (SED) who are not able to receive appropriate mental health services through other entities or through insurers. The six DMH Areas, 29 Local Service Sites and Central Office Division of Child/Adolescent Services are responsible for procuring, contracting for and monitoring all children's services. On interagency issues, EOHHS has taken the responsibility for coordinating, planning, and holding its constituent agencies accountable for results. ESE and DEEC are often asked to participate in interagency planning efforts, and these agencies similarly invite DMH to participate when their activities relate to mental health.

DMH is engaged in numerous interagency activities to promote the mental health of young children. DMH and DPH co-chair the Massachusetts Early Childhood Comprehensive Systems Project (MECCS) that works both within and outside the Department of Public Health to coordinate services for young children birth to five. Target areas for MECCS include: social-emotional development and mental health; early care and education; parenting education and family support. DEEC, which licenses all childcare programs in the state, and Mass Health have jointly funded clinical positions, based in community clinics selected by childcare programs, to provide consultation, training and triage for children with behavioral problems. Many of these children exhibit symptoms of Post Traumatic Stress Disorder or other early traumas. DEEC also funds clinical consultation to day care programs, inviting DMH to participate in its provider selection process.

Several projects serve children through an integrated service approach involving social services, education, juvenile justice, and Mass Health. The Mental Health Service Program for Youth (MHSPY), a Robert Wood Johnson Foundation system of care replication project based in a Health Maintenance Organization, has been serving children at risk of out-of-home placement since March 1998. The five MHSPY sites together have the capacity to serve an average of 80 children at a time. In July 2003, building on the successes of MHSPY and the Worcester Communities of Care, a successful federal systems of care demonstration project, the Commonwealth introduced Comprehensive Family Focused Care (CFFC), a new integrated community mental health initiative for children and families enrolled in Mass Health in five designated sites across the state. CFFC is provider-based, rather than HMO-based and its five sites can each serve 50 youth at a time. Through the CFFC program, EOHHS agencies and DOE

are blending funds to provide children and families with family-focused, strength-based integrated care planning and intensive community-based mental health services. Worcester Communities of Care was chosen as a CFFC site, and it has been able to share its expertise with others while creating a stable source of ongoing funding for itself. Mass Health is the lead agency, and MBHP, its mental health and substance abuse managed care vendor, is providing administrative oversight. Other principal state agencies, including DMH and ESE, provide funding for CFFC, based on an agreed upon case rate. Measures of success for CFFC include: improved child functioning; improved family functioning; increased community tenure; improved school attendance and performance; reduced involvement with juvenile justice; and caregiver and child satisfaction. The CFFC model has also shown success in preventing out-of-home placement. In 2005, CMHS awarded another systems of care grant to Central Massachusetts Communities of Care (CMCC) to serve Worcester County, excluding the city of Worcester, and focused on youth with SED at risk of involvement with the juvenile justice system. Primary measures of success for that program are reduction in the use of DYS detention and Child in Need of Services (CHINS) filings. As a complementary activity to CMCC, ESE is also paying for the introduction of school-based Positive Behavioral Interventions and Support (PBIS) into selected schools within the CMCC service area. EOHHS is the grantee, with DMH providing administrative oversight.

The Collaborative Assessment Program (CAP) is an ongoing DMH-Department of Children and Families project, administered by the latter, that provides a single point of entry to state services for families not previously involved with the Department of Children and Families or DMH who have a child with serious emotional disturbance (SED) who is at-risk of out-of-home placement. CAP offers intensive wraparound services and short-term placement if necessary to stabilize the immediate situation, and links parents with other parents who have had experience raising children with SED in the community. Mass Health contributes funding for wraparound services to its clients served by CAP. Jointly developed operational standards, joint Department of Children and Families-DMH supervision of the CAP director, and ongoing training assure uniformity in program operations and data. PAL conducts the training for the parent partners. The latest evaluation data show that the CAP has been successful in preventing out-of-home placements.

DMH and the Department of Children and Families have collaborated to change daily practice in both agencies to better address the needs of service provision for parents with mental illness and improve outcomes for children. DMH changed its practice to offer short term services to adult applicants who were DCF involved, cross-training has been provided so that workers in each system better understand the resources and also the regulatory environment in which each works, and DMH consults to DCF regarding service planning for children with mental health problems and for those whose parents have mental illness.

In addition to the collaboration with ESE described above, each DMH Area funds community and school support contracts with providers to offer training and consultation to local schools and/or local school systems and thus support mainstreaming. The focus of training is usually to help school staff understand the needs of children with serious emotional disturbance, develop sensitive and effective classroom responses to children

with SED, identify children at suicidal risk and implement suicide prevention strategies, respond to individual or community trauma, and facilitate referrals to mental health services. In some Areas, DMH funded staff participate on student support teams within schools. DMH is also a co-funder and Steering Committee member of an EOHHS pilot project involving state agencies and 13 school districts and educational collaboratives to improve linkages between schools and mental health and social services. DMH and members of PAL, the parent organization, are members of the Statewide Advisory Committee on Special Education. Finally, DMH works closely with advocacy organizations such as Massachusetts Advocates for Children and the Federation for Children with Special Needs to promote understanding of the mental health system and help insure trainings and materials are helpful to parents and to providers working with children with mental health problems.

DMH has a long standing commitment to including those with a dual diagnosis of serious mental illness and substance abuse in its programs and services and in providing them with integrated treatment. Eight years ago, DMH incorporated program standards for the care and treatment of individuals with co-occurring disorders into its Residential Services contracts. In addition, training requirements for managing individuals with co-occurring disorders were included in DMH's SFY'04 Psychiatry Residency and Psychology Internship Training Program contract.

To increase access and the quality of services, DMH has been an active member of an Interagency Work Group (IWG) established by the Department of Public Health in 2001 that meets monthly. Membership includes the Departments of Children and Families, Youth Services, Mental Retardation and Transitional Assistance, MBHP, the Juvenile Court and the Parent Professional Advocacy League (PAL) and selected substance abuse providers, as well as DMH. The IWG goals are to build common understanding and vision across state systems; design and implement a community centered system of comprehensive care for youth with behavioral health disorders that incorporates evidence based practice; coordinate service delivery across systems; simplify administrative processes; and develop purchasing strategies that maximize federal and state dollars. The goal continues to be to resolve those issues inherent in mental health and substance abusing clients who are serviced in both systems and to identify the emerging needs and resources necessary for a successful course of treatment. This past year, DMH offered a training series in Motivational Interviewing which is an evidenced-based practice for dually diagnosed adolescents and young adults, with more in-depth training proposed for the next fiscal year.

As noted in Criterion 1, at a systems level, DMH works closely with the Massachusetts Chapter of the American Academy of Pediatrics, particularly with its mental health task force which includes DMH, the Department of Children and Families and ESE as members as well as pediatricians, nurses, and parents. The Academy has been successful on one of its key agenda items, which was to secure agreement from the state's major HMOs to reimburse for mental health screening. The group is now looking carefully at mental health services in schools, including support for school nurses. DMH serves on the Steering Committee of the Consortium for Children with Special Health Care Needs to assure that the special service and case management needs of children with SED are addressed within the design of a Medical Home. DMH also funds the Massachusetts Child Psychiatry Access Project (MCPAP), administered by MBHP with

DMH funding, that makes psychiatric consultation available to pediatric practices to improve primary care as it relates to mental health, to address concerns about psychiatric medication and to assess the need for and assist in referrals to specialized mental health treatment. Seventy-eight percent of the pediatric practices in the state are enrolled. This service is offered free of charge to the pediatrician and thus is available for all children regardless of their insurance status. A pilot building on the MCPAP concept to provide consultation to schools was inaugurated last year, and funding is expected for the upcoming year.

As a majority of children in the state have some of their mental health treatment covered by private insurance, that population must be considered as well when talking about an integrated system providing comprehensive services. Massachusetts passed mental health parity legislation in 2000 mandating coverage for both acute and intermediate care and created an ombudsman resource at DPH to oversee managed care implementation. Because there had not previously been a formal mechanism by which the state could collect data about the privately insured, an insurance committee was created by the Mental Health Commission for Children that includes DMH, the Division of Insurance, DPH and parents to look at non-Mass Health populations (i.e., privately insured children) in an effort to review the ways in which private health plans respond to children with mental health needs.. The insurance committee revised HMO reporting standards and is now working with the insurers to standardize the definitions and coding used for intermediate care services. As the state moves toward implementation of the Rosie D court order, one of the challenges will be to create a provider network that can serve both the publicly and privately insured to afford continuity of care as children move on and off of Mass Health.

Having a well-funded system of integrated services remains the highest priority for parents and advocates as well as for the state itself. Most of the planning for service system development and integration is taking place under the aegis of the Children's Behavioral Health Initiative (CBHI). Most of the member of the Mental Health Commission for Children, and the subsequent advisory group, are members of the CBHI Advisory Group. That group is advising on implementation of the remedy for the Rosie D lawsuit as a first priority, but at the same time looking beyond the legal remedy to questions of how the current system can be refined to enhance issues of access and system integration among state agencies and between the state and private insurers.. Health Care for All, an advocacy organization, has taken the lead for the Children's Mental Health Campaign that successfully gained support for passage of An Act Improving and Expanding Behavioral Health Services for Children in the Commonwealth. Key elements of the very comprehensive original bill passed this year, , such as providing for mental health consultation to pre-schools and expansion of mental health parity legislation, and the coalition behind the bill intends to continue its work next year to address those components that did not pass. , Also, the Mental Health Task Force of the Massachusetts Chapter of the American Academy of Pediatrics and the Professional Advisory Committee on Children's Mental Health, a subcommittee of the Mental Health Planning Council, continue to look broadly and with a cross-agency, cross-payer perspective at the issue of children's mental health.

Massachusetts

Child - Geographic Area Definition

Child - Establishes defined geographic area for the provision of the services of such system.

Criterion 3: Children's Service

Geographic Area Definition

DMH has six Areas, 29 Local Service Sites and a Central Office Division of Child/Adolescent Services. Central Office and the Areas are responsible for procuring, contracting for and monitoring all children's services. Case management is provided through the Local Service Sites. DMH Areas and Sites are closely but not perfectly aligned with Department of Children and Families' Regions and Local Area Offices. Other agencies, such as DYS and MBHP have larger service areas, encompassing more that one DMH Area. Specific guidelines are in place to ensure local representation for planning and service delivery from all relevant parties and agencies where agency boundaries are not aligned.

Massachusetts

Child - Outreach to Homeless

Child - Describe State's outreach to and services for individuals who are homeless

Criterion 4: Targeted services to rural, homeless and older adult populations

Outreach to Homeless

DMH demonstrates its commitment to confronting homelessness through significant efforts in increasing and improving housing options and services for homeless individuals as well as through interagency collaboration. This collaboration includes a number of task groups dealing with both policy and service delivery issues. Activities related to housing and homelessness are coordinated by the housing staff at Central Office through the Homeless Initiative (HI).

The Homeless Initiative (HI) primarily provides clinical and residential services to support clients in community-based housing and leverages over $150 million in federal and other housing resources to fund both the development of and client access to housing units. Most of this funding is obtained through the U.S. Department of Housing and Urban Development (HUD) McKinney funds.

Since FY 1992, the DMH Homeless Initiative has enabled DMH to create a capacity for serving and placing an average of 2,400 homeless individuals with mental illness each year. DMH also has developed or gained access to more than 1,200 new units of housing. The program, which is operated statewide with a concentration in the Boston area, is presently funded at $25.7 million per year through state appropriations. In FY 2007, DMH received its first appropriation of new, additional Homeless Initiative funds in four years, totaling $3.2 million. This increase in funding allowed DMH to leverage 140 to 180 new units of housing.

DMH's primary statewide outreach and services effort is supported by a $1.4 million per year federal Projects for Assistance in Transition from Homelessness (PATH) grant from the Center for Mental Health Services and $600,000 in state funds. Under the program, clinical social workers regularly visit mainly adult homeless shelters, across the state, to connect with persons with mental illness and provide them with such assistance as direct care, housing search, and advocacy and referrals to key services. The referrals are to such programs as job training, literacy education, mental health services, substance abuse treatment, and benefits and entitlements. Adults and older adolescents, determined to have a serious and persistent mental illness are referred for DMH eligibility determination. In federal FY 2006, PATH clinicians reached and screened 7,578 individuals throughout the state, with 4,555 becoming PATH clients and receiving on-site assistance and referrals to a range of services.

In addition, DMH contributes funding for outreach to homeless individuals with mental illness in transitional housing, on the streets, and in less populated areas of the state. Members of outreach teams do active street work, ride in medical vans and visit emergency shelters. Physicians from affiliated agencies are available to provide medical care to homeless individuals who will not come into a center or shelter for treatment. The Aggressive Street Outreach program serves individuals and families living in shelters or on the streets in Boston, Waltham, Lowell, Lawrence and Quincy. The program includes successful referrals to housing, detoxification and mental health services.

DMH also manages adult transitional residences for homeless individuals with mental illness in the Metro Boston Area. These programs receive referrals from non-DMH shelters and are oriented towards stabilization and placement. Each program is affiliated with a DMH community mental health center (CMHC) and has clinically

trained staff. The Mobile Homeless Outreach Team in the Metro Boston Area identifies adolescents and adults in need of services and connects them to entitlement programs, case management and other services. The Team also provides psychiatric nurses to non-DMH Boston shelters to treat health problems and manage medication adherence.

DMH and the Department of Public Health (DPH) have been collaborating on a statewide program, the Aggressive Treatment and Relapse Prevention program (ATARP). This program is funded at $1.98 million over three years by a HUD McKinney grant, with an additional $525,000 from DMH and $495,000 from DPH over three years. ATARP has been providing housing and services for homeless clients who have a co-occurring mental illness and substance abuse disorder. Family members of clients can receive housing and services as well. ATARP houses and serves approximately 65 individuals and seven to nine families each year.

In regards to children and families, DMH has agreements across the state between Family Substance Abuse Treatment Shelters, DMH and the Department of Public Health. These agreements were created to strengthen the understanding of the mental health needs of youth in shelters and to provide information about community resources offered by DMH that may be appropriate for families in shelters. As a result of this collaboration, staff has information on access to care, psychopharmacological interventions, signs and symptoms of high-risk behaviors and appropriate use of Emergency Service Programs.

As homelessness increases in the transition age youth population, the services and supports that surround young adults are prioritizing housing options and mentoring services. Efforts at the Area level include the involvement of housing coordinators with the transition age youth point persons and the Young Adult Advisory Councils to increase the number of housing choices available for transition age youth. DMH is also providing some consultation to the child service agencies about housing options for their clients who may have some behavioral health problems but who mostly likely do not meet adult eligibility criteria.

DMH also participates in a number of high-level interagency task forces and work groups focused on reducing the problem of homelessness. The Massachusetts Interagency Council on Housing and Homelessness, chaired by the Lt. Governor, has been specifically addressing the needs of homeless people with mental illness. An Interagency Workgroup on Chronic Homeless Services, chaired by DMH and the Department of Transitional Assistance (Welfare) has been meeting to improve housing and service delivery to the population of chronically homeless adults, particularly those with a mental illness, substance abuse or co-occurring disorders. Key state agencies, homeless advocates and private sector providers have been participating in the Chronic Homeless Workgroup and its task groups. These interagency workgroups are continuing under the leadership of the new governor and administration and DMH will continue to play an active role.

Massachusetts

Child - Rural Area Services

Child - Describes how community-based services will be provided to individuals in rural areas

Criterion 4: Targeted services to rural, homeless and older adult populations

Rural Area Services

DMH does not have a separate division or special policies for adults, children or adolescents who reside in less populated areas of the state. Each of DMH's 29 Sites has at least one town or incorporated city with a population greater than 15,000 that is considered the center of economic activity for the area. None of the Sites has a population density below 100 people per square mile.

The primary goal of DMH's local planning process is to address the issue of access to services for all DMH clients. Each Site plan identifies target population, needs, available services and resources, gaps in services and resources, and barriers to implementation of a local service delivery system. Geographic distribution of the population is not an issue. Poverty of clients and lack of insurance are more significant variables since the lack of financial resources to pay for transportation interferes with the client's physical ability to get to where services are located and the lack of insurance limits availability. A particular focus relevant to rural populations continues to be access to transportation. At the Area level, many clients have identified this as a challenge. In child and adolescent service contracts, for example, transportation is one of the flexible supports often provided.

Massachusetts

Child - Resources for Providers

Child - Describes financial resources, staffing and training for mental health services providers necessary for the plan;

DMH has chosen to integrate the adult and child narrative for this section of the plan for the following reasons. First, the Child and Adolescent Division of DMH resides within Program Operations at Central Office. New applicants who are age 18 and who meet adult eligibility criteria are entered as adults; if they do not meet adult criteria they may become eligible under the child/adolescent criteria. Individuals under the age of 19 may receive adult services when clinically appropriate as adults over the age of 19 may receive child and adolescent services when appropriate. Furthermore, DMH has placed significant emphasis on planning for transition age youth between the ages of 16 and 25. This age grouping encompasses both the child/adolescent and adult systems. Lastly, the Rosie D Class, as described in the Executive Summary, includes children up to age 21. DMH recognizes the need for its child, adolescent and young adult services to align with and complement Rosie D services.

Massachusetts

Child - Emergency Service Provider Training

Child - Provides for training of providers of emergency health services regarding mental health;

DMH has chosen to integrate the adult and child narrative for this section of the plan for the following reasons. First, the Child and Adolescent Division of DMH resides within Program Operations at Central Office. New applicants who are age 18 and who meet adult eligibility criteria are entered as adults; if they do not meet adult criteria they may become eligible under the child/adolescent criteria. Individuals under the age of 19 may receive adult services when clinically appropriate as adults over the age of 19 may receive child and adolescent services when appropriate. Furthermore, DMH has placed significant emphasis on planning for transition age youth between the ages of 16 and 25. This age grouping encompasses both the child/adolescent and adult systems. Lastly, the Rosie D Class, as described in the Executive Summary, includes children up to age 21. DMH recognizes the need for its child, adolescent and young adult services to align with and complement Rosie D services.

Massachusetts

Child - Grant Expenditure Manner

Child - Describes the manner in which the State intends to expend the grant under Section 1911 for the fiscal years involved

DMH has chosen to integrate the adult and child narrative for this section of the plan for the following reasons. First, the Child and Adolescent Division of DMH resides within Program Operations at Central Office. New applicants who are age 18 and who meet adult eligibility criteria are entered as adults; if they do not meet adult criteria they may become eligible under the child/adolescent criteria. Individuals under the age of 19 may receive adult services when clinically appropriate as adults over the age of 19 may receive child and adolescent services when appropriate. Furthermore, DMH has placed significant emphasis on planning for transition age youth between the ages of 16 and 25. This age grouping encompasses both the child/adolescent and adult systems. Lastly, the Rosie D Class, as described in the Executive Summary, includes children up to age 21. DMH recognizes the need for its child, adolescent and young adult services to align with and complement Rosie D services.

CHILD - GOALS TARGETS AND ACTION PLANS

Transformation Activities: ☑

Name of Performance Indicator: Increased Access to Services (Number)

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Fiscal Year	FY 2006 Actual	FY 2007 Actual	FY 2008 Projected	FY 2009 Target	FY 2010 Target	FY 2011 Target
Performance Indicator	2,860	2,290	2,849	2,830	2,830	2,830
Numerator	N/A	N/A	--	--	--	--
Denominator	N/A	N/A	--	--	--	--

Table Descriptors:

Goal: Maintain the number of DMH eligible child and adolescent clients receiving a continuing care community mental health service

Target: 2,830 DMH eligible child and adolescent clients will receive a continuing care community mental health service each fiscal year

Population: DMH eligible child and adolescent clients

Criterion: 2:Mental Health System Data Epidemiology
3:Children"s Services

Indicator: # of DMH child and adolescent clients receiving a community service during each fiscal year

Measure: # of DMH child and adolescent clients receiving a community service during each fiscal year

Sources of Information: DMH Child and Adolescent Database

Special Issues: Although DMH contibutes funding to interagency direct service projects, DMH is not the administrator and therefore children enrolled in these services are not included in this indicator. Also, children receiving forensic evaluations through the juvenile court clinic who are not receiving other DMH services, are not included in this indicator.

Significance: DMH’s enrolled population refers to those who apply for and are determined eligible for DMH continuing care community services, for whom no other options, outside of DMH, exist. DMH services include individual and family flex supports, day services, case management and community residential and respite care.

Action Plan: This indicator will be included in a monthly Community Indicator Report which will be made available to DMH managers throughout the state, with the expectation that managers utilize this data for program managment and quality improvement purposes. The eligibility determination process was changed in 2007 to be more user-friendly with earlier phone and face-to-face contact and a simplified Request for Services form. However, these changes are not expected to increase the number of eligible clients as the eligibility criteria remain the same.

CHILD - GOALS TARGETS AND ACTION PLANS

Transformation Activities: ☑

Name of Performance Indicator: Reduced Utilization of Psychiatric Inpatient Beds - 30 days (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Fiscal Year	FY 2006 Actual	FY 2007 Actual	FY 2008 Projected	FY 2009 Target	FY 2010 Target	FY 2011 Target
Performance Indicator	0	0	0	1	1	1
Numerator	0	0	--	--	--	--
Denominator	61	39	--	--	--	--

Table Descriptors:

Goal: Increase community tenure of DMH eligible child and adolescent clients

Target: To increase community tenure by maintaining the 30-day readmission rate of DMH child and adolescent clients to state-operated inpatient facilities at no more than 1% each year.

Population: DMH child and adolescent eligible clients discharged from continuing care inpatient services

Criterion: 1:Comprehensive Community-Based Mental Health Service Systems
3:Children"s Services

Indicator: % of child and adolescent clients discharged from continuing care inpatient services who are readmitted to continuing care inpatient services within 30 days

Measure: # of child and adolescent clients discharged from continuing care inpatient services who are readmitted to continuing care inpatient services within 30 days/# of child and adolescent clients discharged from continuing care inpatient services

Sources of Information: DMH Child and Adolescent Database

Special Issues: DMH does not have state hospitals for children. It funds two contracted continuing care units located on state hospital grounds. Most admissions to these units occur after one or more acute inpatient community hospitalizations. The 30-day readmission rate to continuing care units does not represent the hospitalization experience of DMH child and adolescent clients as a readmission will most likely take place in an acute-care inpatient facility. At this time, access to Mass Health and private insurance readmission data is limited.

Significance: The monitoring of readmission rates has achieved high priority within DMH with the increased focus on the integration of acute and continuing care behavioral health services. The monitoring of inpatient utilization data allowed DMH to close one adolescent unit in FY 2007.

Action Plan: The Readmission Collaborative, formed in November 2006, has been developing and implementing strategies aimed at reducing acute-care readmission rates of DMH clients who receive Mass Health benefits through the Massachusetts Behavioral Health Partnership (MBHP).

CHILD - GOALS TARGETS AND ACTION PLANS

Transformation Activities: ☑

Name of Performance Indicator: Reduced Utilization of Psychiatric Inpatient Beds - 180 days (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Fiscal Year	FY 2006 Actual	FY 2007 Actual	FY 2008 Projected	FY 2009 Target	FY 2010 Target	FY 2011 Target
Performance Indicator	0	2.56	1	2	2	2
Numerator	0	1	--	--	--	--
Denominator	61	39	--	--	--	--

Table Descriptors:

Goal: Increase community tenure of DMH eligible child and adolescent clients

Target: To increase community tenure by maintaining the 180-day readmission rate of DMH child and adolescent clients to state-operated inpatient facilities at no more than 2% each year.

Population: DMH child and adolescent eligible clients discharged from continuing care inpatient services

Criterion: 1:Comprehensive Community-Based Mental Health Service Systems
3:Children"s Services

Indicator: % of child and adolescent clients discharged from continuing care inpatient services who are readmitted to continuing care inpatient services within 180 days

Measure: # of child and adolescent clients discharged from continuing care inpatient services who are readmitted to continuing care inpatient services within 180 days/# of child and adolescent clients discharged from continuing care inpatient services

Sources of Information: DMH Child and Adolescent Database

Special Issues: DMH does not have state hospitals for children. It funds two contracted continuing care units located on state hospital grounds. Most admissions to these units occur after one or more acute inpatient community hospitalizations. The 180-day readmission rate to continuing care units does not represent the hospitalization experience of DMH child and adolescent clients as a readmission will most likely take place in an acute-care inpatient facility. At this time, access to Mass Health and private insurance readmission data is limited.

Significance: The monitoring of readmission rates has achieved high priority within DMH with the increased focus on the integration of acute and continuing care behavioral health services. The monitoring of inpatient utilization data allowed DMH to close one adolescent unit in FY 2007.

Action Plan: The Readmission Collaborative, formed in November 2006, has been developing and implementing strategies aimed at reducing acute-care readmission rates of DMH clients who receive Mass Health benefits through the Massachusetts Behavioral Health Partnership (MBHP).

CHILD - GOALS TARGETS AND ACTION PLANS

Transformation Activities: ☑

Name of Performance Indicator: Evidence Based - Children with SED Receiving Therapeutic Foster Care (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Fiscal Year	FY 2006 Actual	FY 2007 Actual	FY 2008 Projected	FY 2009 Target	FY 2010 Target	FY 2011 Target
Performance Indicator	19	0	29	29	29	29
Numerator	N/A	0	--	--	--	--
Denominator	N/A	N/A	--	--	--	--

Table Descriptors:

Goal: Maintain the number of DMH child and adolescent clients receiving therapeutic foster care.

Target: To provide therapeutic foster care to 29 child and adolescent clients each fiscal year

Population: DMH child and adolescent clients

Criterion: 1:Comprehensive Community-Based Mental Health Service Systems
3:Children"s Services

Indicator: # of DMH child and adolescent clients receiving therapeutic foster care

Measure: # of DMH child and adolescent clients receiving therapeutic foster care

Sources of Information: DMH Data Warehouse

Special Issues: DMH's aim is to assure access to therapeutic foster care when needed. However, DMH's goal is to keep children in their own homes whenever possible through provision of intensive supports. While Therapeutic Foster Care is used for temporary respite care as well as for residential care, the numbers above do not include children admitted to this service for respite. The availability of homes for DMH clients is affected, at times, by the requirement of the Department of Children and Families that a foster home not accept a child from another agency while they have a child from Children and Families in residence.

Significance: Therapeutic foster care provides a normative environment for children who need to be removed from their own home.

Action Plan: DMH continues to contract for therapeutic foster care.

CHILD - GOALS TARGETS AND ACTION PLANS

Transformation Activities: ☐ **Indicator Data Not Applicable:** ☑

Name of Performance Indicator: Evidence Based - Children with SED Receiving Multi-Systemic Therapy (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Fiscal Year	FY 2006 Actual	FY 2007 Actual	FY 2008 Projected	FY 2009 Target	FY 2010 Target	FY 2011 Target
Performance Indicator	N/A	N/A	N/A	N/A	N/A	N/A
Numerator	N/A	N/A	--	--	--	--
Denominator	N/A	N/A	--	--	--	--

Table Descriptors:

Goal:

Target:

Population:

Criterion: 1:Comprehensive Community-Based Mental Health Service Systems
3:Children"s Services

Indicator:

Measure:

Sources of Information:

Special Issues: While individual programs in the state may be providing multi-systemic therapy, DMH does not currently monitor or directly fund this evidence-based practice.

Significance:

Action Plan:

CHILD - GOALS TARGETS AND ACTION PLANS

Transformation Activities: ☐ **Indicator Data Not Applicable:** ☑

Name of Performance Indicator: Evidence Based - Children with SED Receiving Family Functional Therapy (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Fiscal Year	FY 2006 Actual	FY 2007 Actual	FY 2008 Projected	FY 2009 Target	FY 2010 Target	FY 2011 Target
Performance Indicator	N/A	N/A	N/A	N/A	N/A	N/A
Numerator	N/A	N/A	--	--	--	--
Denominator	N/A	N/A	--	--	--	--

Table Descriptors:

Goal:

Target:

Population:

Criterion: 1:Comprehensive Community-Based Mental Health Service Systems
3:Children"s Services

Indicator:

Measure:

Sources of Information:

Special Issues: While individual programs in the state may be providing family functional therapy, DMH does not currently monitor or directly fund this evidence-based practice as this is recognized as an acute-care, rather than a continuing care service in the state.

Significance:

Action Plan:

CHILD - GOALS TARGETS AND ACTION PLANS

Transformation Activities: ☐

Name of Performance Indicator: Client Perception of Care (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Fiscal Year	FY 2006 Actual	FY 2007 Actual	FY 2008 Projected	FY 2009 Target	FY 2010 Target	FY 2011 Target
Performance Indicator	56.37	53.18	54	55	56	57
Numerator	115	159	--	--	--	--
Denominator	204	299	--	--	--	--

Table Descriptors:

Goal: To increase the number of families who perceive DMH care to be a positive intervention

Target: To increase the percentage of family members of child and adolescent clients receiving case management services who report positively about the outcomes of their child on the annual consumer and family member satisfaction survey by 1% each year

Population: DMH child and adolescent clients who receive case management services

Criterion: 1:Comprehensive Community-Based Mental Health Service Systems
3:Children"s Services

Indicator: % of family members of child and adolescent clients receiving case management services who report positively about outcomes of their child on the annual consumer and family member satisfaction survey

Measure: # of family members of child and adolescent clients receiving case management services reporting positively about outcomes of their child on the annual consumer and family member satisfaction survey/# of family members of child and adolescent clients receiving case management services completing the outcomes section of the anuual consumer and family member satisfaction survey

Sources of Information: Annual Consumer and Family Member Satisfaction Survey

Special Issues: In 2006, DMH initiated an annual statewide Consumer and Family Member Satisfaction Survey. DMH contracted with the Center for Mental Health Services Research (CMHSR) at the University of Massachusetts to conduct this survey. Utilizing the MHSIP Consumer Survey tool, a random sample of DMH clients and family members are stratified by program type each year. Adults receiving case management services and family members of children/adolescents receiving case management services are included in the survey each year in order to maintain a consistent population for establishing benchmarks and targets. Therefore, it is important to note that while the survey samples several program types, only family members of children and adolescents receiving case management services are included in the denominator of this goal.

Significance: DMH initiated an annual statewide consumer and family member satisfaction survey in 2006 in order to meet federal reporting requirements and to provide data for program management and quality improvement purposes. DMH recognizes the importance of this survey in providing valuable information on the experience and outcomes of individuals who receive services provided by DMH and their families.

Action Plan: DMH is currently conducting its third annual Consumer and Family Member Satisfaction Survey. A DMH advisory group is working with CMHSR to further refine the survey methodology, improve response rates to provide valid data to meet reporting requirements, and inform program management and quality improvement efforts. In 2008, meetings were held with Central Office and Area leadership to identify areas for further data analysis and to identify opportunities for Area and statewide improvement.

CHILD - GOALS TARGETS AND ACTION PLANS

Transformation Activities: ☐

Name of Performance Indicator: Child - Return to/Stay in School (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Fiscal Year	FY 2006 Actual	FY 2007 Actual	FY 2008 Projected	FY 2009 Target	FY 2010 Target	FY 2011 Target
Performance Indicator	53.85	61.30	57	58	59	60
Numerator	56	179	--	--	--	--
Denominator	104	292	--	--	--	--

Table Descriptors:

Goal: Increase the likelihood that child and adolescent clients return to and stay in school

Target: To increase the percentage of family members of DMH child and adolescent clients receiving case management services who report that their child's attendance in school has improved in the last 12 months or since beginning services on the annual consumer and family member satisfaction survey by 1% each year

Population: DMH child and adolescent clients receiving case management services

Criterion: 1:Comprehensive Community-Based Mental Health Service Systems
3:Children"s Services

Indicator: % of family members of DMH child and adolescent clients receiving case management services who reported on the annual consumer and family member satisfaction survey that their child's attendance in school has improved in the last 12 months or since beginning services

Measure: # of family members of DMH child and adolescent clients receiving case management services who reported on the annual consumer and family member satisfaction survey that their child's attendance in school has improved in the last 12 months or since beginning services / # of family members of child and adolescent clients receiving case management services who complete the school attendence section of the annual consumer and family member satisfaction survey

Sources of Information: Annual Consumer and Family Member Satisfaction Survey

Special Issues: In 2006, DMH initiated an annual statewide Consumer and Family Member Satisfaction Survey. DMH contracted with the Center for Mental Health Services Research (CMHSR) at the University of Massachusetts to conduct this survey. Utilizing the MHSIP Consumer Survey tool, a random sample of DMH clients and family members are stratified by program type each year. Adults receiving case management services and family members of children/adolescents receiving case management services are included in the survey each year in order to maintain a consistent population for establishing benchmarks and targets. Therefore, it is important to note that while the survey samples several program types, only family members of children and adolescents receiving case management services are included in the denominator of this goal. Administrative data regarding school attendence are not currently available. Once DMH case managers begin to use the CANS assessment tool, school attendance will be looked at quarterly.

Significance: DMH initiated an annual statewide consumer satisfaction survey in 2006 in order to meet

federal reporting requirements and to provide data for program management and quality improvement purposes. DMH recognizes the importance of this survey in providing valuable information on the experience and outcomes of individuals who receive services provided by DMH, particularly the outcome of school involvement. DMH hopes to reverse the trend by which children with SED drop out of school at a higher rate than children with any other disability.

Action Plan: DMH is currently conducting its third annual Consumer and Family Member Satisfaction Survey. A DMH advisory group is working with CMHSR to further refine the survey methodology, improve response rates to provide valid data to meet reporting requirements, and inform program management and quality improvement efforts. In 2008, meetings were held with Central Office and Area leadership to identify areas for further data analysis and to identify opportunities for Area and statewide improvement.

CHILD - GOALS TARGETS AND ACTION PLANS

Transformation Activities: ☑

Name of Performance Indicator: Child - Decreased Criminal Justice Involvement (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Fiscal Year	FY 2006 Actual	FY 2007 Actual	FY 2008 Projected	FY 2009 Target	FY 2010 Target	FY 2011 Target
Performance Indicator	80	68.29	70	71	72	73
Numerator	4	28	--	--	--	--
Denominator	5	41	--	--	--	--

Table Descriptors:

Goal: To decrease the involvement of DMH child and adolescent clients in the juvenile justice system.

Target: To increase the percentage of family members of DMH child and adolescent clients receiving case management services who report that their child was arrested and not rearrested in the last 12 months or since beginning services on the annual consumer and family member satisfaction survey by 1% each year

Population: DMH child and adolescent clients receiving case management services

Criterion: 1:Comprehensive Community-Based Mental Health Service Systems
3:Children"s Services

Indicator: % of family members of child and adolescent clients receiving case management services who reported on the annual consumer and family member satisfaction survey that their child was arrested and not rearrested in the last 12 months or since beginning services

Measure: # of family members of child/adolescent clients receiving case management services who reported on the annual consumer and family member satisfaction survey that their child was arrested and not rearrested in the last 12 months or since beginning services /# of family members of child/adolescent clients receiving case management services who reported on the annual consumer and family member satisfaction survey that their child was arrested in the last 12 months or since beginning services

Sources of Information: Annual Consumer and Family Member Satisfaction Survey

Special Issues: In 2006, DMH initiated an annual statewide Consumer and Family Member Satisfaction Survey. DMH contracted with the Center for Mental Health Services Research (CMHSR) at the University of Massachusetts to conduct this survey. Utilizing the MHSIP Consumer Survey tool, a random sample of DMH clients and family members are stratified by program type each year. Adults receiving case management services and family members of children/adolescents receiving case management services are included in the survey each year in order to maintain a consistent population for establishing benchmarks and targets. Therefore, it is important to note that while the survey samples several program types, only family members of children and adolescents receiving case management services are included in the denominator of this goal. Administrative data regarding arrests and juvenile justice involvement are not currently available. Once DMH case managers begin to use the CANS assessment tool, juvenile justice involvement will be looked at quarterly.

Significance: DMH initiated an annual statewide consumer and family member satisfaction survey in 2006 in order to meet federal reporting requirements and to provide data for program management and quality improvement purposes. DMH recognizes the importance of this survey in providing valuable information on the experience and outcomes of individuals who receive services provided by DMH, particularly in regards to juvenile justice involvement.

Action Plan: DMH is currently conducting its third annual Consumer and Family Member Satisfaction Survey. A DMH advisory group is working with CMHSR to further refine the survey methodology, improve response rates to provide valid data to meet reporting requirements, and inform program management and quality improvement efforts. In 2008, meetings were held with Central Office and Area leadership to identify areas for further data analysis and to identify opportunities for Area and statewide improvement. In addition, the DMH Forensic Transition Teams have been serving adolescent clients statewide.

CHILD - GOALS TARGETS AND ACTION PLANS

Transformation Activities: ☐

Name of Performance Indicator: Child - Increased Stability in Housing (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Fiscal Year	FY 2006 Actual	FY 2007 Actual	FY 2008 Projected	FY 2009 Target	FY 2010 Target	FY 2011 Target
Performance Indicator	N/A	N/A	4	4	4	4
Numerator	N/A	N/A	--	--	--	--
Denominator	N/A	N/A	--	--	--	--

Table Descriptors:

Goal: To increase stability in housing for DMH eligible children and adolescents

Target: To prevent an increase in the number of DMH child and adolescent clients who receive case management services and are homeless

Population: DMH eligible child and adolescent clients receiving case management services

Criterion: 1:Comprehensive Community-Based Mental Health Service Systems
3:Children"s Services

Indicator: Number of child and adolescent clients who are homeless

Measure: # of child and adolescent clients receiving case management services who are homeless/# of child and adolescent clients receiving case management services

Sources of Information: DMH Data Warehouse

Special Issues: The children identified as homeless were those who had run from state funded programs or who were age 18 and refused to live with their parents. DMH makes every effort to locate these youth, to establish and maintain contact with them, and to obtain stable living arrangements for them.

Significance: DMH realizes the impact of homelessness on child development, and recognizes the safety risks of living on the streets or in shelters. DMH offers a range of residential support services to meet the individual needs of clients, and reaches out to those who initially refuse services, or run away at a later date.

Action Plan: DMH continues to promote quality improvement activities in residential programs to reduce runaway behavior.

CHILD - GOALS TARGETS AND ACTION PLANS

Transformation Activities: ☐

Name of Performance Indicator: Child - Increased Social Supports/Social Connectedness (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Fiscal Year	FY 2006 Actual	FY 2007 Actual	FY 2008 Projected	FY 2009 Target	FY 2010 Target	FY 2011 Target
Performance Indicator	76.21	78.15	77	78	79	80
Numerator	157	236	--	--	--	--
Denominator	206	302	--	--	--	--

Table Descriptors:

Goal: Increase social connectedness of DMH child and adolescent clients

Target: To increase the percentage of family members of child and adolescent clients receiving case management services who report positively about their child's social connectedness on the annual consumer and family member satisfaction survey by 1% each year

Population: DMH child and adolescent clients receiving case management services

Criterion: 1:Comprehensive Community-Based Mental Health Service Systems
3:Children"s Services

Indicator: % of family members of child and adolescent clients receiving case management services who report positively about the social connectedness of their child on the annual consumer and family member satisfaction survey

Measure: # of family members of child and adolescent clients receiving case management services reporting positively about the social connectedness of their child on the annual consumer and family member satisfaction survey/# of family members of child and adolescent clients receiving case management services completing the social connectedness section of the annual consumer and family member satisfaction survey

Sources of Information: Annual Consumer and Family Member Satisfaction Survey

Special Issues: In 2006, DMH initiated an annual statewide Consumer and Family Member Satisfaction Survey. DMH contracted with the Center for Mental Health Services Research (CMHSR) at the University of Massachusetts to conduct this survey. Utilizing the MHSIP Consumer Survey tool, a random sample of DMH clients and family members are stratified by program type each year. Adults receiving case management services and family members of children/adolescents receiving case management services are included in the survey each year in order to maintain a consistent population for establishing benchmarks and targets. Therefore, it is important to note that while the survey samples several program types, only family members of children and adolescents receiving case management services are included in the denominator of this goal.

Significance: DMH initiated an annual statewide consumer and family member satisfaction survey in 2006 in order to meet federal reporting requirements and to provide data for program management and quality improvement purposes. DMH recognizes the importance of this survey in providing valuable information on the experience and outcomes of individuals who receive services provided by DMH, particularly the social connectedness of clients as a protective factor.

Action Plan: DMH is currently conducting its third annual Consumer and Family Member Satisfaction Survey. A DMH advisory group is working with CMHSR to further refine the survey methodology, improve response rates to provide valid data to meet reporting requirements, and inform program management and quality improvement efforts. In 2008, meetings were held with Central Office and Area leadership to identify areas for further data analysis and to identify opportunities for Area and statewide improvement.

CHILD - GOALS TARGETS AND ACTION PLANS

Transformation Activities: ☐

Name of Performance Indicator: Child - Improved Level of Functioning (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Fiscal Year	FY 2006 Actual	FY 2007 Actual	FY 2008 Projected	FY 2009 Target	FY 2010 Target	FY 2011 Target
Performance Indicator	42.64	42.08	43	44	45	46
Numerator	84	93	--	--	--	--
Denominator	197	221	--	--	--	--

Table Descriptors:

Goal: To improve level of functioning of DMH child and adolescent clients

Target: To increase the percentage of family members of child and adolescent clients receiving case management services who report an improved level of functioning of their child on the annual consumer and family member satisfaction survey by 1% each year

Population: DMH child and adolescent clients receiving case management services

Criterion: 1:Comprehensive Community-Based Mental Health Service Systems
3:Children"s Services
4:Targeted Services to Rural and Homeless Populations

Indicator: % of family members of child and adolescent clients receiving case management services who report improved level of functioning of their child on the annual consumer and family member satisfaction survey

Measure: # of family members of child and adolescent clients receiving case management services reporting improved level of functioning of their child on the annual consumer and family member satisfaction survey/# of family members of child and adolescent clients receiving case management services completing the level of functioning section of the annual consumer and family member satisfaction survey

Sources of Information: Annual Consumer and Family Member Satisfaction Survey

Special Issues: In 2006, DMH initiated an annual statewide Consumer and Family Member Satisfaction Survey. DMH contracted with the Center for Mental Health Services Research (CMHSR) at the University of Massachusetts to conduct this survey. Utilizing the MHSIP Consumer Survey tool, a random sample of DMH clients and family members are stratified by program type each year. Adults receiving case management services and family members of children/adolescents receiving case management services are included in the survey each year in order to maintain a consistent population for establishing benchmarks and targets. Therefore, it is important to note that while the survey samples several program types, only family members of children and adolescents receiving case management services are included in the denominator of this goal. Previously, DMH had reported on client functioning through the CAFAS (Child and Adolescent Functional Assessment Scale), but because this data only captured information on children and adolescents who received case management services for a full year, it did not reflect the improved functioning of children who were successfully discharged from case management services.

Significance: DMH initiated an annual statewide consumer and family member satisfaction survey in 2006 in

order to meet federal reporting requirements and to provide data for program management and quality improvement purposes. DMH recognizes the importance of this survey in providing valuable information on the experience and outcomes of individuals who receive services provided by DMH. DMH is particularly interested in understanding the impact of services on the outcomes and level of functioning of individuals served.

Action Plan: DMH is currently conducting its third annual Consumer and Family Member Satisfaction Survey. A DMH advisory group is working with CMHSR to further refine the survey methodology, improve response rates to provide valid data to meet reporting requirements, and inform program management and quality improvement efforts. In 2008, meetings were held with Central Office and Area leadership to identify areas for further data analysis and to identify opportunities for Area and statewide improvement. It is important to note that in both the 2006 and 2007 Family Member Satisfaction Surveys, a smaller percentage of parents reported improvement in their child's level of functioning compared to the percent who reported improvement in the specific domains of school attendance, juvenile justice involvement and social connectedness.

CHILD - GOALS TARGETS AND ACTION PLANS

Transformation Activities: ☐

Name of Performance Indicator: Case Management

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Fiscal Year	FY 2006 Actual	FY 2007 Actual	FY 2008 Projected	FY 2009 Target	FY 2010 Target	FY 2011 Target
Performance Indicator	53.80	58.60	53	53	53	53
Numerator	1,974	2,052	--	--	--	--
Denominator	3,666	3,502	--	--	--	--

Table Descriptors:

Goal: Maintain case management services for DMH eligible children and adolescents

Target: 53% of DMH child and adolescent clients will receive case management services each fiscal year

Population: DMH child and adolescent clients

Criterion: 1:Comprehensive Community-Based Mental Health Service Systems

Indicator: % of DMH child and adolescent clients receiving case management services

Measure: # of DMH child and adolescent clients receiving case management services / # of DMH child and adolescent clients

Sources of Information: DMH Data Warehouse

Special Issues: Although regulations state that each child shall receive state-operated case management services, DMH does not have sufficient resources to achieve this goal. This indicator does not include care coordination provided through contracted providers. State agency case management will be reviewed in the context of the Children's Behavioral Health Initiative as many children currently eligible for DMH case management will be eligible for Intensive Case Coordination through the CBHI.

Significance: Parents rate case management services for children and adolescents as the most useful service provided by DMH.

Action Plan: DMH continues to make every effort to retain a stable number of case managers and is committed to at least maintaining the percentage of clients receiving case management services at the current level.

CHILD - GOALS TARGETS AND ACTION PLANS

Transformation Activities: ☐

Name of Performance Indicator: Cultural Competence

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Fiscal Year	FY 2006 Actual	FY 2007 Actual	FY 2008 Projected	FY 2009 Target	FY 2010 Target	FY 2011 Target
Performance Indicator	91.50	90.20	90	91	92	93
Numerator	151	238	--	--	--	--
Denominator	165	264	--	--	--	--

Table Descriptors:

Goal: To provide culturally competent care to DMH child and adolescent clients and their families

Target: To increase the percentage of family members of DMH child and adolescent clients receiving case management services who report that staff were sensitive to their cultural background on the annual consumer and family member satisfaction survey by 1% each year

Population: DMH eligible child and adolescent clients receiving case management services

Criterion: 1:Comprehensive Community-Based Mental Health Service Systems

Indicator: % of family members of DMH child and adolescent clients receiving case management services who report that staff were sensitive to their cultural background on the annual consumer and family member satisfaction survey

Measure: # of family members of DMH child and adolescent clients receiving case management services who report that staff were sensitive to their cultural background on the annual consumer and family member satisfaction survey/# of family members of DMH child and adolescent clients receiving case management services who responded to the question regarding staff sensitivity to their cultural background on the annual consumer and family member satisfaction survey

Sources of Information: Annual Consumer and Family Member Satisfaction Survey

Special Issues: In 2006, DMH initiated an annual statewide Consumer and Family Member Satisfaction Survey. DMH contracted with the Center for Mental Health Services Research (CMHSR) at the University of Massachusetts to conduct this survey. Utilizing the MHSIP Consumer Survey tool, a random sample of DMH clients and family members are stratified by program type each year. Adults receiving case management services and family members of children/adolescents receiving case management services are included in the survey each year in order to maintain a consistent population for establishing benchmarks and targets. Therefore, it is important to note that while the survey samples several program types, only family members of children and adolescents receiving case management services are included in the denominator of this goal.

Significance: DMH initiated an annual statewide consumer and family member satisfaction survey in 2006 in order to meet federal reporting requirements and to provide data for program management and quality improvement purposes. DMH is interested in analyzing the data from the consumer and family member satisfaction survey regarding issues of race, ethnicity and cultural sensitivity in order to improve provision of culturally competent care.

Action Plan: DMH is currently conducting its third annual Consumer and Family Member Satisfaction

Survey. A DMH advisory group is working with CMHSR to further refine the survey methodology, improve response rates to provide valid data to meet reporting requirements, and inform program management and quality improvement efforts. The advisory group made several improvements to the survey in 2008 to improve the response rate and appropriateness of the survey for cultural and linguistic minorities. One improvement is the use of interpreters and translated surveys and materials for DMH clients with a preferred language other than English, including the use of ASL interpreters. The survey and related materials were translated into 10 languages in 2008. In addition, several questions were added to the survey regarding the availability of translated materials and interpreters in service delivery. In 2008, meetings were held with Central Office and Area leadership to identify areas for further data analysis and to identify opportunities for Area and statewide improvement.

CHILD - GOALS TARGETS AND ACTION PLANS

Transformation Activities: ☑☐

Name of Performance Indicator: Parents with Mental Illness

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Fiscal Year	FY 2006 Actual	FY 2007 Actual	FY 2008 Projected	FY 2009 Target	FY 2010 Target	FY 2011 Target
Performance Indicator	138	238	100	100	200	200
Numerator	N/A	N/A	--	--	--	--
Denominator	N/A	N/A	--	--	--	--

Table Descriptors:

Goal: Provide timely interventions to parents with mental illness in order to protect and promote the mental health of their children

Target: To provide timely interventions to 138 adult applicants for DMH who are also involved with the Department of Children and Families (DCF)

Population: Adult applicants for DMH services who are also DCF involved

Criterion: 3:Children"s Services

Indicator: # of adult applicants for DMH service who indicate DCF involvement on their application and receive a DMH service while their application is pending

Measure: # of adult applicants for DMH service who indicate DCF involvement on their application and receive a DMH service while their application is pending

Sources of Information: MHIS and Area reports

Special Issues: One of the six DMH Areas automatically determines that any adult parent applicant who is DCF-involved is eligible for DMH. Therefore, this Area's data are not included in this indicator as it is not a service provided pending eligibility.

Significance: DMH expects that timely inteventions will promote child health, safety and well-being. Parenting, as a domain of adult functioning, has not historically been given the attention it needs. DMH, through the Parents with Mental Illness Initiative is taking steps towards addressing the needs of this population.

Action Plan: DMH will continue to examine the needs of adolescents and adults who are parenting and will address these needs in future procurements. Parental status is a field on the new Request for Services form as a part of the eligibility determination process. DMH will meet with the Department of Children and Families to develop strategies to raise awareness and increase use of DMH services and consultation for parents who are involved in the child welfare system.

CHILD - GOALS TARGETS AND ACTION PLANS

Transformation Activities: ☑☐

Name of Performance Indicator: Restraint Prevention

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Fiscal Year	FY 2006 Actual	FY 2007 Actual	FY 2008 Projected	FY 2009 Target	FY 2010 Target	FY 2011 Target
Performance Indicator	N/A	N/A	N/A	N/A	N/A	10
Numerator	N/A	N/A	--	--	--	--
Denominator	N/A	N/A	--	--	--	--

Table Descriptors:

Goal: To reduce the use of restraint in DMH-contracted residential programs.

Target: To be determined for 2010; to reduce by 10% in 2011 (see Action Plan below)

Population: DMH child and adolescent clients in residential treatment programs

Criterion: 1:Comprehensive Community-Based Mental Health Service Systems

Indicator: # of reported incidents of restraint (per 1,000 resident days) in DMH-contracted residential treatment programs

Measure: # of reported incidents of restraint (per 1,000 resident days) in DMH-contracted residential treatment programs selected for the initial stage of implementation

Sources of Information: DMH Restraint Database

Special Issues: The DMH Child and Adolescent Division has had significant success in reducing the use of restraint in inpatient and intensive residential treatment programs. This revised indicator moves the initiative to the community. Initial collection of data on incidents of restraint in residential programs began in FY 2008, but data from different sources are not comparable.

Significance: DMH recognizes the importance of trauma-sensitive interventions and the client and progam-level benefits from the reduced use of restraint. This unifies the philosophical orientation to treatment.

Action Plan: As described in Criterion I, the Child and Adolescent Restraint Reduction Initiative is beginning to implement a statewide process targeting residential programs. In FY 2009 a standard data gathering strategy will be decided upon and data collection begun to start the process of establishing a baseline. In FY 2010 data will be analyzed and a baseline established. The target for FY 2011 is a 10% reduction from the baseline to be established in FY 2010.

Massachusetts

Planning Council Letter for the Plan

Upload Planning Council Letter for the Plan

The Commonwealth of Massachusetts
Executive Office of Health and Human Services
Department of Mental Health
MENTAL HEALTH ADVISORY COUNCIL
State Mental Health Planning Council

July 25, 2008

Barbara Leadholm, Commissioner
Department of Mental Health
25 Staniford Street
Boston, MA 02114

Dear Commissioner Leadholm,

The Mental Health Planning Council (Council), a subcommittee of the Mental Health Advisory Council, met on July 17, 2008 to review the State Mental Health Plan as part of the Commonwealth's Community Mental Health Services Block Grant application. We are writing to provide you the Council's reactions and comments.

Please be advised the Council unanimously voted to re-approve the three-year plan for SFY 2008-2010 it had approved last year, as well as a new Executive Summary and other related documentation presented at the meeting.

Having just learned that the 2008-2010 plan had only been approved for one year, and that DMH would be submitting a new three year plan, the Council also approved additions or revisions necessary to submit a plan for SFY 2009-2011.

Historically, the Council has used its annual review meeting as well as this letter to address issues and concerns which extend beyond the four corners of the Plan and our review task. We believe this has resulted in productive and ongoing dialogue on issues of importance to the mental health community. Moreover, on a number of occasions we have seen our recommendations and comments become DMH policy, thereby providing the Council with additional credibility and strengthening the cooperative spirit among the diverse stakeholders on the Council and within the broader mental health community.

The Council used the meeting to hear reports from a number of its sub-committees as well as remarks on elder mental health issues from Michael E. Festa, Secretary of Elder Affairs. Although an ambitious agenda, it proved to be a worthwhile exercise because it demonstrated to the almost 70 people in attendance, including three block grant site monitors, the Council's vibrancy as well as how several Council initiatives had grown into imaginative and productive programs or activities. Accordingly, we have included in this letter our comments on the Plan and an outline of the meeting so that other interested parties can read about the Council's good work, DMH, and the benefit which inures to

the mental health community when stakeholder involvement and collaboration are encouraged in the public planning process.

We are grateful you were able to attend a good portion of the meeting, and that members of your senior management team and other DMH staff remained throughout. In addition to providing important credibility to the Council and its deliberations, your presence and that of senior staff allowed Council members to direct questions or comments and receive prompt and unfiltered answers or responses.

Commissioner's Comments:

The Council was pleased to hear you report on three priorities as you reflected on the first year of your tenure as Commissioner:

- The Request for Information which DMH issued as part of the process to re-procure its community-based services. This is the first in 10 years, and we share your commitment to structuring a community-based system that reflects recovery, resiliency and the importance of employment in the recovery process.
- The FY 2009 Budget was the first in several years that did not cut DMH's base. Because of the declining economy there is little, if any, growth, and DMH will be required to look for ways to enhance programs and create efficiencies.
- The establishment of a DMH Quality Council and the bridging of information between the area offices and the central office are significant. DMH will continue its work to collect the data necessary to support decision-making and to determine proper indicators for performance evaluations.

In response the Council wants to again express its ongoing support for the Department's vision of a community-based, recovery-focused, consumer and family-driven system of care and the importance of treatment, housing, employment, and peer supports in that system. Moreover, we firmly support efforts to build capacity throughout the system to ensure we have accurate and current data, appropriate workforce training and development, effective outcome measurements, and coordination with other agencies.

Comments on the Plan and Updated Plan Documents:

Council members were pleased that advance copies of the documents were provided as well as the fact the Plan is available and can be downloaded from the DMH Web site. We applaud DMH's efforts to involve the Council in the earliest stages of the Plan's development and this enhances our collective ability to review and comment on its provisions.

- A member noted the work DMH and others are doing to move clients from expensive private psychiatric hospitals and units to other locations. There has been "improvement" in the so-called "stuck adults" issue and perhaps it should be highlighted in the Executive Summary.
- Members praised the clarity and organization of the Executive Summary.

- A member encouraged more collaboration with MassHealth (Medicaid) to enhance programs.
- A member noted that the large number of elders, who have mental health issues and receive home care services, demonstrates the need for more collaboration between and among human service agencies.
- A member suggested DMH make a stronger effort to include "family voice" in more of its committees, working groups and at all levels of policy and practice development.
- A member noted the reference to developing an "Employment Assessment" to collect data on employment (page 13 of Adult/Goals/Targets and Action Plans) and suggested DMH consider the recommendations set forth in the Report of the Council's sub-committee on Employment.
- On employment, a member stated DMH was undercounting the number of its clients who are working because it does not include those who are also clubhouse members. We were advised that part of the difficulty is ensuring the stated number is an unduplicated count, and the Department is working on the issue with clubhouses and others.
- Several members lamented the lack of a current "central clearing house" of information on programs, availability of services and other information that would be helpful for discharge planning.
- A member suggested that as part of the Quality Council process, DMH should partner with family, consumer and peer voices.

Michael E. Festa, Secretary of Elder Affairs:

- Secretary Festa expressed appreciation for the breadth of diversity represented on the Council, and said that he accepted our invitation to speak because he had made elder mental health a priority.

- He talked about his Secretariat's emerging partnerships with local Councils on Aging in order to assist in the early identification of seniors with mental health needs. The local Councils on Aging with their senior centers and Meals on Wheels programs are well positioned to identify those seniors who need help.

- Secretary Festa believed if elders needing help could be identified, local cities and towns would actually save money on other municipal resources these elders use, such as emergency rooms and calls to the fire and police departments. The strategy is to identify this population and to get resources for help. Pilot projects, using incentive grants, have been set up with local councils in the hopes of developing a model, which could be replicated across the Commonwealth.

Elder Mental Health Sub-Committee

The Council's Elder Mental Health sub-committee made its report while Secretary Festa was present so that the two could interact and discuss potential collaboration. The following points were made and discussed.

- Co-Chair Jim Callahan briefly outlined the history of the sub-committee, which began as a statewide elder mental health coalition more than a decade ago and was invited two years ago to become a sub-committee of the Council. A resource directory targeted at seniors and caregivers, now in its third printing, was initially created from federal (EBI) funding with Council support.
- As adult DMH clients living in the community get older, they should not be directed (or pushed) towards nursing homes or rest homes simply because of advanced age. Instead, their unique housing needs should be addressed.
- Organized advocacy is key. As housing and other resources dwindle, the senior community can lose out because of the availability of institutions such as nursing homes, which target the senior population.
- DMH cannot do it alone, since many elders do not meet the current eligibility criteria. Therefore, collaboration between DMH and Elder Affairs is critical.

Statewide Youth Advisory Committee

- Matthew McWade, chair of the Statewide Youth Advisory Committee, an outgrowth of another sub-committee of the Council, showed a video presently airing on YouTube. Several young men in various settings discussed their mental illnesses and the path each took to recovery.
- Council members were very impressed with both the message and the technical quality of the video and offered ideas to increase the number of viewers.
- A Council member noted that one of the programs cited in the video as having had a profound impact on an individual's recovery had received support from the Council several years earlier, when its continued existence was threatened.

Sub-Committee on Employment

- A member of the Employment sub-committee outlined its history. The Council created it on August 30, 2006 because a significant number of Council members believed that an effort should be made to make employment, including self-employment and volunteer opportunities, a central part of the fabric of the DMH delivery of care system. Council members believed that DMH and every DMH client, provider, case manager, clinician, and program should understand that employment is just as critical to recovery as treatment, housing, and peer support.
- The initial report of the sub-committee was a series of recommendations and principles that it urged DMH to include in any re-procurement documents it might issue in the years ahead. The full Council adopted the report on April 9, 2007.
- Since DMH had issued a Request for Information (RFI) as part of the re-procurement of its community-based services, the sub-committee wanted the Council to approve the filing of a response to the RFI, which incorporated the recommendations of the sub-committee report. A copy of the proposed Response was provided to Council members, and upon a motion duly made and seconded, it was voted to file the document as the Council's response to the RFI.

Family Options Program

- Toni Wolfe, Executive Director of Employment Options clubhouse, briefed the Council on Family Options, their pioneering program to help parents with mental illnesses and their children. The program's initial focus is on non-custodial issues and includes an innovative clubhouse legal support project, which receives block grant funds from DMH, with Council approval.
- Many parents with mental illnesses lose custody of their children and very often are not even allowed visitation. The Family Options program assists parents who desire to reconnect with their children. It is estimated that 10% of the DMH adult client population are parents.
- In addition to helping with non-custodial issues, the program encourages clubhouses to take steps to make certain its activities are "kid friendly" and urges all providers to ascertain the parental status of their clients.
- The program asked Council members for input as to how to move the program forward as well as identifying resources to sustain it. Among the suggestions offered by members were:
    - Educational outreach to the Courts.
    - Create a focus group of young adult parents with mental illnesses
    - Create a parent peer-counseling program with the goal of getting it certified.
    - Create a "parenting" sub-committee of the Council to focus on these issues.
- Ms. Wolfe asked those members of the Council from human service agencies who are filing a response to DMH's RFI, to include a mention of the Family Options program or target population. Information on the program was distributed to Council members.

The Council is grateful for the work you have done as Commissioner of the Department of Mental Health and the energy and commitment you have brought to this demanding position. We believe you have assembled an extraordinary leadership team to work with the highly professional and competent staff at DMH. We are greatly impressed by the quality of work being done by Beth Lucas and Judy Pina in connection with the Planning Council.

We believe this year's block grant review meeting was extraordinary in terms of attendance and discussion, and in demonstrating the progress that has been made by DMH, the Council and its sub-committees. It is impressive that initiatives which were once just ideas endorsed and proposed for funding by the Council, are today providing important support, services and advocacy for children, adolescents, adults and seniors with mental illnesses and their families.

We believe the successes the Council has enjoyed are a testament both to the dedication and hard work of its individual members, and to the commitment, integrity and professionalism of DMH staff, yourself, and past Commissioners who have had the

wisdom and confidence to empower all stakeholders by listening and by involving them in the planning and policy development process.

Sincerely,

Bernard J. Carey, Jr.
Co-Chair

Massachusetts

Appendix A (Optional)

OPTIONAL- Applicants may use this page to attach any additional documentation they wish to support or clarify their application. If there are multiple files, you must Zip or otherwise merge them into one file.

THE COMMONWEALTH OF MASSACHUSETTS
EXECUTIVE DEPARTMENT
STATE HOUSE • BOSTON 02133
(617) 725-4000

DEVAL L. PATRICK
GOVERNOR

TIMOTHY P. MURRAY
LIEUTENANT GOVERNOR

August 1, 2007

LouEllen M. Rice
Grants Management Officer
Division of Grants Management, OPS
Substance Abuse and Mental Health Services Administration
1 Choke Cherry Road, Room 7-1091
Rockville, MD 20850

Dear Ms. Rice:

I hereby authorize JudyAnn Bigby, M.D., Secretary of the Executive Office of Health and Human Services, to make assurances, sign applications and agreements, and perform any similar acts on my behalf relevant to the Community Mental Health Services Block Grant, as may be required now or in the future.

Sincerely,

cc: JudyAnn Bigby, M.D., Secretary, Executive Office of Health and Human Services
James Morrow, Project Officer, Center for Mental Health Services